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THE UNIVERSITY OF ALBERTA

WOMEN'S EXPERIENCE OF DEPRESSION

by

MARJ HOLMGREN

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF DOCTOR OF PHILOSOPHY

IN

COUNSELLING PSYCHOLOGY

Department of Educational Psychology

EDMONTON, ALBERTA

Fall, 1987

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A Woman Cries

A woman cries. Her daughter has just announced that she is pregnant. The daughter does not know these tears, she does not understand this reaction or its meaning, and her unarticulated questions search for an answer. Are these tears of joy? No. There is no hidden smile, no light in the eyes, no attempts of congratulatory embrace. Are these the tears of shame? No. The daughter carries all the social sanctions of law, church, and acceptable length of marriage. Are these the tears of disappointment? How could that be so? It would be too confusing. Isn't this what the woman did, what a woman is supposed to do--become wife and mother? Certainly this is what Dad always wanted her to do!

Still, a woman cries. She cries inside, yet the tears are seen. She cries alone, yet the seasoning of those tears taste of her "knowing" and her daughter's need to "know." She cries silently, and yet the tears speak an unspoken language that touches her daughter's heart. She is crying the unspoken answers to her daughter's unspoken questions.

Years later, the daughter "hears" those answers and another woman cries.

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled WOMEN'S EXPERIENCE OF DEPRESSION submitted by MARJ HOLMGREN in partial fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY in COUNSELLING PSYCHOLOGY.

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External Examiner

Date August 24, 1987

DEDICATION

This is dedicated to my mother, Eleanor Starkey Nix, with the hope that she would have liked the sound of her voice as it joined our voices in speaking this manuscript. It was she who taught me to hear sound in silence.

Abstract

The present study explores how women who have experienced depression describe that experience and what meaning that experience holds for them now that they are no longer depressed. The exploration is hermeneutical in nature. Eight women and the author identified one or more of their life's experiences as depression and participated in hermeneutical conversations which focused on their experiences of depression. Metaphors, messages to depressed women, and ten descriptive themes--the "self," fear, isolation, social withdrawal, change, control, loss, issues, helplessness, and social context or circumstances--which emerged from these conversations are presented and discussed in terms of balance/imbalance and other dichotomies, meaning, the current literature on depression, and implications for counselling.

Acknowledgements

I would like to express my appreciation to Dr. R. Liburd, thesis supervisor, whose enthusiasm and encouragement made it possible for me to bring this study together and whose ongoing involvement, support, expertise, and creative ideas were invaluable to its completion. Appreciation is also extended to the co-supervisor, Dr. L. Stewin, and the members of the thesis committee, Dr. A. Vander Well, Dr. T. Craig, Dr. D. Cullen, Dr. R. Frender, and Dr. L. Woolsey for their assistance, encouragement, and helpful participation throughout this study.

Special thanks are extended to the women who participated in this study and gave so generously of their experiences, so that this study was possible. Their enthusiasm for this study sustained me and gave me a sense of privilege for having known them.

I wish, also, to thank Ms. Sandy Boychuk for her efforts, above and beyond the call of duty, in producing this final typed presentation. Her skill and vigilence were appreciated by the committee, as well as by me.

Finally, I would like to thank my children, Laura and Kristi; my grandchildren, Tommy, Michael, and Carli; and all the other people whose presence in my life allowed me to believe in myself and supported me throughout this study. They gave new meaning to the term, significant-other.

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I. INTRODUCTION

This study is described metaphorically as a voyage, one chapter in this captain's log book of voyages and experiences. This was a circular voyage in that it began in and returned to experience, the Land-of-Experience. Circularity sometimes gives the impression that one returns unchanged to a beginning point which also remains unchanged. This study does not hold such an impression. Rather, it recognizes change in both the sailor and her port.

This voyage was undertaken as a search for an understanding of one of life's experiences--the experience of depression. It began with my personal experience of depression. It was from this Land-of-Experience that I set sail in search of knowledge that would help me understand the experience of depression. The chart for this voyage directed me to the Land-of-What-Is-Said (the existing literature on depression and methodology), to other ports in the Land-of-Experience inhabited by the women in this study, and back to my home port. It is at that port that I took down my sails and the voyage came to an end--not "The End," but an end, nonetheless.

The log book for this voyage took the form of a personal journal. In that journal were chronicled people, events, work procedures, readings, thoughts, feelings, and anything that seemed important to the description of that voyage. This is one person's log of one voyage. It is not presented as a definitive description that would fit everyone's experience. It is my experience as it met the experiences of eight women during conversations that were part of this particular study or voyage.

A. Beginnings

In "A Woman Cries," I was the daughter. My questions were not articulated, neither were my mother's answers. Through the hindsight of experience, I came to a knowing, a possible consensus born of shared experience, shared meaning, and my resulting tears may have encouraged the sprouting of the seeds of articulation or bringing into language the questions and their assumed answers.

Maybe there was a woman's movement, but it didn't touch us in our lower-middle-class home in the mid-west United States. My mother lived a life of silence. Although she never said it, it was understood that women don't talk about

"certain things." We didn't talk about our bodies, menstruation, sex, marriage, pregnancy, or emotions--especially not about psychological distress! Consequently, we didn't talk about her depression [then it was called a nervous breakdown]. Even in the final months beside her hospital bed, we didn't talk about death. It seemed that women's lives and issues, like death, were not something one talks about. There were so many things not to talk about, that we never talked at all.

Without woman-talk, I had to make certain assumptions about the meaning of her tears, a meaning born of her own experience. Her experience could not be the same as mine. The world had changed and I was not exactly like my mother. Yet, I had the sense that she was telling me something that I could not understand at that time.

Many years later, I experienced tears of my own and they wore a new label--depression. The following brief description of that experience is presented as the true beginning of this study. It was out of that experience that the research question emerged and it was out of that experience that I heard the experiences of the women in this study.

My experience became noticeable in August, 1980, lasted a little over two years, and did not receive the label, depression, until I was coming out of the experience. My imagery for those years was me as a trapeze performer. In August, 1980, I stepped off the high platform and began swinging on a trapeze, back and forth, knowing that at some time I had to let go in order to reach the other swing and the other side. During the moment I let go, the film stopped and I was in a still-frame, suspended mid-air, nothing to hang on to and utterly alone. Eventually, the film began again and I caught the other swing. After a period of swinging again, I finally touched the other platform with my toes and eventually found myself on the other side having successfully survived the experience.

Stepping off the platform was my decision to leave my university teaching position of eleven years, move to Los Angeles to build a career in a different aspect of the music business, and live separately from my husband, daughter, and family home. The first swing was an enthusiastic move forward, but it very soon began to swing back. There was a great financial strain and a lot of necessary adjustment just to cope with my new living conditions. In addition, three people important to me died: my

grandfather, my aunt, and my dear friend and business partner. In the space of eight months, I had suffered many losses and changes.

For every swing forward, there was a swing back. Indecision kept me from letting go. The risk was too great. I had stepped off the platform to explore my potential, to find out who I was, and to own my life by having control of that life. My expectation had been to enjoy the thrill of stepping off, have a few swings, and then step back on the platform I knew. However, my outside world did not stay stable as I explored my "self" and, eventually, there was no way to get my feet back on familiar ground. My marriage was disintegrating and my relationships with my daughters and old friends were being strained. At that time, everything that was familiar seemed unavailable to me and all I could do was hold on.

There was no way to go back. In time, I didn't want to. Letting go seemed the only option open to me, but the other trapeze swing was nowhere in sight. At that time, everything that was happening around and to me was interpreted as a confirmation that there was something wrong with me, that I had failed, and that I was without value. Simultaneously, I was feeling pulled down by the weight of all the people that wanted me to attend to them, to respond. It was a struggle to respond to myself. There was no energy left. I wanted to be dead to everyone and everything, so I methodically cut myself off from people and activities. I wanted them to let go of me, so that I could let go of everything. This was my period of suspension in air--nothing to hold on to and totally alone.

I was frightened, terribly frightened. I felt helpless. The feelings I had were so overwhelming that I had to turn off feeling in every way possible just to endure the experience. Somehow, I managed to function at work without any major disasters. As I look back on that time, I was actually moderately successful, but I wasn't able to see that then. My vision was very selective. It only saw black. I felt paralyzed, unable to feel and unable to grow. I couldn't accept myself and my failures. Nothing seemed worthwhile. I was not worthwhile. It was a terrible space and I was stuck in it.

The film and I began to move again when one person reached through the distance I had put between me and the world and touched me with words of encouragement and acceptance. The movement was slight at first, but it gained

momentum when I began to explore existential questions and my spirituality. I had damaged and lost my spirit during this experience and now had to rebuild and regain that spirit. Reading books and experiencing the out-of-doors began to breathe life into my being-in-the-world. Just as I began to want to live again, the other trapeze swing appeared.

I got a divorce, moved to Colorado, and began taking some college courses. During that time, I was successful in courses that I never thought I could comprehend. I was encouraged to pursue a degree program in counselling psychology and I began to believe I could do it. It was during a chat with a psychologist at my undergraduate practicum placement that my experience, in retrospect, was given the label, depression.

This labelling came as a surprise to me. I didn't know much about depression, except that I had experienced it. During the five years since that labelling, I have wanted to know more about that experience and have explored what the literature had to say about it. The knowledge I found seemed incomplete and too far removed from my experience. I knew that I still didn't know and I wanted to know what other women who had experienced depression had to say. At that point, the research question addressed in this study emerged: How do women who have experienced depression describe this experience and what meaning does that experience hold for them now that they are no longer depressed? It was a question I had asked myself and now wanted to ask other women.

B. The Question and Its Organization

The present study intends to explore depression through the life-worlds of women who have experienced depression. Through this exploration, it intends to describe women's experience of depression and understand the meaning this experience holds for these women. Its starting point is not theory, but experience. It begins with my experience from which the question emerges. It considers the literature and what we know of depression. It considers the method and procedure of searching for an answer to the question. It returns to the experience of depression as the source of knowing what that experience is. Finally, it ends with a discussion of what we know about depression after considering the experience of nine women--eight participants and one

researcher.

In this chapter, the question is articulated and the context from which the question arose is briefly described. In Chapter II, the relevance of the question is addressed in the context of a literature review. Through a review of the existing literature on depression, it describes why the question needs to be asked and of whom it needs to be asked.

Chapter III explores methodology, the choice of an appropriate method of inquiry. The research question asks for a description of the experience called depression and asks for the meaning of that experience. The character of the question led to the choice of hermeneutics, in the tradition of Heidegger and Gadamer, as an appropriate method of inquiry for this study. In Chapter III, Gadamer's hermeneutics, as it is presented in Truth and Method (1986), is discussed. In addition, the choice of hermeneutics for this study was influenced by my values and beliefs as a woman and feminist. These values and beliefs are discussed in Chapter III through an exploration of my understanding of feminism and feminist research methodology.

Chapter IV presents the prooedure followed in this study. The women who participated and shared their depression experience in this study are described. The research process, which incorporated a modified collaboration between the researcher and participants through reflective accounts of the depression experience, dialogal interviews (conversations), and hermeneutic encounters with the transcripts of those conversations, is presented in four phases. Each phase is described and discussed.

Chapter V presents the themes that emerged from the materials generated by the research process. These themes describe the collective experience of depression as it emerged during this study. These themes are presented in two parts: 1) Inside themes that describe the inner experience of depression, and 2) Outside themes that describe what was going on outside these women during their depression. In addition to themes, Chapter V presents the participants' metaphors for depression as they responded to my question: "How does depression feel?" Finally, Chapter V presents each participant's message to depressed women in a section entitled, "Tell Depressed Women . . . ". Each section of this chapter provides a different perspective in describing depression. These three perspectives are intended to provide a complete picture of the depression

experience as it emerged in this study and a picture that could not be seen from one perspective alone.

Chapter VI discusses the description of depression provided in Chapter V. In this discussion, the existing literature on depression is reconsidered in the light of descriptions of that experience presented by the women in this study. Meaning is discussed in two ways: 1) the meaning depression holds for the participants as it appeared to me during this study, and, 2) the meaning depression holds for me in light of the results of this study. Finally, the implications this study has for counselling women who are depressed or have been depressed is discussed.

The final chapter, Chapter VII, is an epilogue. In that chapter, Phase IV of the research process is presented along with the participants' reactions to this dissertation and the total research process. It concludes with my reactions to this study and its results, as well as the changes I experienced as I pulled down my sails and reflected on this voyage.

II. CONTEXT

> A person who seeks to understand must question what lies behind what is said. He must understand it as an answer to a question. If we go back behind what is said, then we inevitably ask questions beyond what is said. We understand the sense of the text only by acquiring the horizon of the question that, as such, necessarily includes other possible answers. [Gadamer, 1986, p. 333]

An undercurrent throughout this study has been a personal motivation to understand this thing called depression, specifically as it impacts women, so it should not be surprising that this undercurrent washed me upon the shores of the Land-of-What-Is-Said (the existing literature on depression, particularly the literature focused on women and depression). There were different languages spoken on these shores--biology, psychology, and sociology--and communication was difficult (amongst themselves as well as between them and me)! Remembering Palmer's (1969) suggestion that "a certain preunderstanding of the subject is necessary or no communication will happen" (p. 25), I stood there wearing only a preunderstanding of depression hand-stitched from experience--my mother's and my own. Needless to say, it felt like a fragile garment to be wearing when contrasted to the glittering raiment of those who inhabited the Land-of-What-Is-Said. During the ensuing communication (sometimes called a literature critique), I was once again drawn to the words of Palmer (1969) and Gadamer (1986): "understanding must be altered in the act of understanding" (Palmer, 1969, p. 25), and "we inevitably ask questions beyond what is said" (Gadamer, 1986, p. 333). Consequently, the following literature critique[1] is offered as a means of communicating how I moved from the Land-of-Experience, through the Land-of-What-Is-Said and back again (somewhat altered and full of questions) to the Land-of-Experience.

A. Defining Depression

Dictionaries necessarily offer succinct definitions of depression: "an abnormal state of inactivity and unpleasant emotion" (Webster, 1949, p. 223); "an unwarranted and prolonged condition of emotional dejection" (Morehead & Morehead, 1955, p. 129); "in

[1]It may be important to state that this critique represents only my first encounter with the literature on depression. After data collection and interpretation were complete, I returned to the literature. That encounter is integrated into the discussion presented in Chapter 6.

the normal individual a state of despondency characterized by feelings of inadequacy, lowered activity, and pessimism about the future" (Chaplin, 1975, p. 135); "in pathological cases, an extreme state of unresponsiveness to stimuli, together with self-deprecation, delusions of inadequacy and hopelessness" (Chaplin, 1975, p. 135). On the surface, these appear to be clear definitions of depression. However, a closer examination reveals that their simplicity is misleading. Research and improvements in measurement and analysis of psychological disorders have uncovered seeds of definitional confusion. Levitt, Lubin, and Brooks (1982) suggest that the efforts of researchers and theorists to clarify the term depression have, conversely, rendered depression refractory to definition. Some of the definitional confusion can be attributed to the following factors: (1) depression has been used to describe a mood, a symptom, and a syndrome; (2) depression has been defined by its symptomotology; and (3) depression appears to have a wide range of severity.

Depression may be a mood, a symptom of another disorder, or a syndrome. In each case, depression is described and classified according to its symptoms and, in some instances, the severity and duration of those symptoms. It is the classification dilemma that makes depression fertile soil for those who battle "the nature and classification of mental illness as a whole" (Levitt, Lubin, & Brooks, 1982, p. 2), and that renders depression refractory to definition.

Classification according to symptoms presents a problem when "almost every symptom known to psychiatry has been included in the depression syndrome by some theoretician or clinician" (Levitt, Lubin, & Brooks, 1982, p. 3). Watts (1966) recorded the symptoms of 590 office-treated depressives. Of the 71 different symptoms, 32 were present in 1.5 percent or more of the patients. Levitt, Lubin, and Brooks (1982) present 54 symptoms taken from 16 depression measurement inventories and list 33 different depression measurement instruments. This emphasis on symptoms is also seen in the diagnostic instruments used to identify depressed persons in clinical practice and in research.

The third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Spitzer, 1980) published by the American Psychiatric Association (APA) is a widely recognized reference for identifying various mental disorders, including

depression, in clinical practice. The DSM-III presents the following diagnostic criteria for a major depressive episode: (1) dysphoric mood or loss of interest is prominent and relatively persistent; (2) at least four out of eight possible symptoms--significant appetite and weight change, sleep pattern change, agitation or retardation in activity, loss of interest, loss of energy, poor self-esteem or guilt, diminished concentration, and suicide ideation--must be present every day for at least two weeks; and (3) no evidence of organic mental disorder, psychosis, mania, or normal bereavement. The Research Diagnostic Criteria (RDC) (Spitzer, Endicott, & Robins, 1978) presents the following criteria for identifying depressed individuals for research: a persistence of at least two weeks of a dysphoric mood, at least five symptoms of depression, absence of psychosis, and either impaired functioning or seeking of treatment. Both the DSM-III and the RDC offer a wide spectrum of symptoms that are difficult if not impossible to assess directly without the individual's self-report. Moreover, I would suggest that most of us could identify ourselves as depressed at some point in life if these are the symptoms and definition of depression.

Regarding the classification dilemma and, subsequently, the definitional dilemma, Blinder (1969) offers the following:

> Perhaps the greatest problem is that the phenomena lumped together under the term depression are a "mixed bag" containing some essentially physiological disturbances, some symptom complexes with both physiological and psychic disturbance, and some unconscious, habitual patterns of behavior that may bring the patient repeatedly to grief. Any schema of classification attempting to assimilate such an odd assortment is apt to be unsatisfactory as a guide to either diagnosis or treatment. (p. 9)

Symptomotology as a definition of depression is equally unsatisfactory in light of the controversy over symptoms as cause or effect. Are the symptoms associated with depression causal or effectual? After compiling and analyzing a number of research studies dealing with this issue, Levitt, Lubin, and Brooks (1982) conclude "that the available diagnostic tools are often not sufficiently sharp to make the necessary determinations" (p. 19).

Another issue that confuses the efforts to define or classify depression is the variation in diagnostic practices around the world. Rawnsley (1968) presented case record summaries to psychiatrists in five countries for diagnosis. The results indicated tendencies of Americans to diagnose more neurotic and involutional depressions; British and Danish psychiatrists, more psychotic depressions; and Swedish and Norwegian psychiatrists, more neurotic depressions. Differences in the incidence of depression and schizophrenia in Britain and the United States noted by some researchers appear to be differences in diagnostic practices more than actual differences in incidence (Kramer, 1965, 1969; Cooper, Kendell, Gurland, Sartorius, & Farkas, 1969; Cooper, Kendell, Gurland, Sharpe, Copeland, & Simon, 1972; and Gurland, Fleiss, Sharpe, Simon, Barret, Copeland, Cooper, & Kendell, 1972).

Finally, in addition to the RDC and DSM-III, scores on certain psychological tests are used to identify depressed individuals, particularly in research. In a review of depression studies, Rothblum and Green (1979) noted differences in identifying depression in research subjects through cut-off scores on popular inventories such as the Minnesota Multiphasic Personality Inventory (MMPI) Depression Scale, the Beck Depression Inventory, Zung Depression Scale, and the Hamilton Rating Scale. It was observed that some researchers who use test scores as the criteria for identifying depression in their subjects were often using scores lower than the norms that correspond with clinical depression provided by the authors of those inventories (Rothblum, 1983).

Depression's definitional dilemma has some important implications for any review of the literature as well as for future research on depression. First, defining depression according to its symptomotology becomes a problem when the symptoms are numerous and varied and rely so heavily on self-report. Second, depression's symptomotology is not identified as causal or effectual, so it tells us little about depression beyond how it is exhibited. Third, defining depression through symptomotology tends to take our attention away from individuals and towards their symptoms. Fourth, test scores, no matter what their cut-off, on popular depression inventories tend to be reflections of an individual's symptoms and, therefore, bring us around full-circle to the problems of defining depression by its symptomotology. Finally, differences in identifying individuals

as depressed, whether by test scores or symptomotology classification, confound any comprehensive study of the existing literature.

Researchers are asked to describe their sample and population and to present the criteria for the selection of their sample. Given the problems noted above, it would seem that depression can be anything someone says it is. Although this seems too simplistic a conclusion to draw from this discussion of defining depression, it does make it difficult to tell individuals who report having a depression experience that they weren't depressed and we can prove it by test scores and various diagnostic criteria based on symptoms that are best assessed by self-report. Therefore, this study describes depression as an experience reported by the individuals who volunteered for a study of their depression. The criteria for their selection was their self-identification of that experience as depression. The purpose of the study is to describe depression according to their self-reports of that experience.

B. Prevalence

There does not appear to be a consensus in estimating the prevalence of depression in the general population. The National Institute of Mental Health (NIMH) estimated that "four to eight million Americans may be in need of professional care for the depressive illness" (Seligman, 1975, p. 77). Another study indicated that 23 percent of the general population sampled could be considered depressive (Srole, Langner, Opler, & Rennie, 1962). Daly (1978) estimated that 15 percent of the adult American population between the ages of 18 and 75 manifest depressive symptoms. Levitt, Lubin, and Brooks (1982) present a number of studies and estimates of prevalence of depression in the general population and conclude that the disparity in estimates is the product of differences in research methodology and related problems. Weissman and Paykel (1974) also noted the disparity and lack of consensus in estimates and offer the following reasons for the difficulty in translating the general belief that depression is common into numbers: (a) many depressives do not reach psychological help, but will be treated by family physicians, pharmacists, friends, or will receive no identification that would bring them to the attention of any census of depression; (b) the increase in the diagnosis of depression and the corresponding increase in estimates may be an artifact

that reflects "the tendency to fit a diagnosis to a disorder for which there is available treatment" (p. 15); and, (c) the lack of a clear differential definition of depression as a mood, symptom, syndrome, or group of syndromes further confounds attempts to estimate its prevalence in the general population.

While the literature cannot provide a consensus in estimating the prevalence of depression in the general population, the estimates that exist tend to indicate that depression occurs often enough to warrant continued research and attention in the health professions. Part of the continued concern about depression is its link to self-destructive behavior, particularly suicidal death. Depressed persons appear to be at high risk for suicide. "The relationship between depression and suicide appears to be the strongest and most consistent correlate in almost every study of self-destructive behavior" (Goldstein, Baker, & Jamison, 1980, p. 236). Pokorny (1964) found the highest rate of suicides among patients within various psychiatric diagnostic categories were those patients with depressive psychosis. Seligman's (1975) estimate that one out of every 200 persons affected by depressive illness will succeed in suicide is considered a low estimate. Beck and Young (1978) indicated that 46 percent of the college students in their study manifested depressive symptoms intense enough to warrant professional help. Others estimate that of the 10,000 college students who attempt suicide each year, 1,000 will succeed in their attempt (Goldstein et al., 1980). Findings such as these indicate that society is at risk of losing valuable human resources as a result of depression and validate the concern of health professionals inspite of the lack of consensus estimates of the prevalence of depression in the population.

Many studies targeted at estimating the prevalence of depression have noted a preponderance of women in the population identified as depressed (Belle & Goodman, 1980; Frerichs, Aneshensel, & Clark, 1981; Goldman & Ravid, 1980; Sayetta & Johnson, 1980; Vishi, Jones, Shank, & Lima, 1980; Weissman & Klerman, 1977). Seiden (1982) states not only that women outnumber men by large margins in diagnoses of depression, but that the ratio is between 2:1 and 3:1. Others have looked at several countries and find a consistently higher incidence of depression among women than men (Weissman & Klerman, 1977). Footnotes in the DSM-III regarding prevalence and sex ratios lead the diagnostician to look at depression as more common in women than men.

Therefore, we can expect far more women than men to be identified as depressed and treated for depression. Greenspan (1983) estimates that more than 12 million women per year wear this diagnostic label. Even though we can't find consensus in prevalence statistics or consistency in actual ratios for the genders, there is general agreement in the literature that women comprise the largest portion of the population wearing the label, "depression" (Bart, 1975; Beck, 1967; DeRosis & Pellegrino, 1976; Greenspan, 1983; Seiden, 1982; Sturdivant, 1980; Weissman & Klerman, 1977).

Several hypotheses have been set forth to explain the sex difference in incidence of depression and will be discussed in the section on theories of depression. Regardless of any explanation for this sex difference, the fact that more women than men are being targeted and treated for depression has implications for this study. It offers a rationale for limiting the participants in this study to women. This should not indicate any lack of concern for depression in men. Indeed, men exhibit a higher success rate for suicide than women. Depression should be regarded as a human problem rather than gender specific. However, the effects on women of being identified and treated for depression more often than men cannot be ignored. This study simply wishes to limit its scope by addressing only women's experience of depression and takes the preponderance of women in the prevalence literature as its rationale for doing so.

C. Theories of Depression

Theories of depression may be conceived of as falling into three categories: (1) biological, (2) psychological, and (3) sociological or psychosocial. A critical review of each of these categories of theoretical approaches to depression is presented as a brief background to illustrate the multiplicity and diversity of thinking and research that has become associated with our understanding of depression. This particular study is not involved with theory building; therefore, the following brief discussion of depression theory is neither exhaustive nor expansive. Rather, the following discussion will be limited to an overview of biological, psychological, and sociological theories of depression, particularly depression in women, as I understood them prior to commencing this study.

Biological Theories

Overall, the variety of biological theories of depression has demonstrated a tendency to concentrate more on treatment than cause. However, when cause is addressed, biological theories are most likely to look at internal rather than external events that precipitate or are concomitant to depression. On the other hand, psychological theories have tended to look at external events, no matter how far removed, as precipitating depression. Perhaps this has been a factor in separating medical and psychological approaches to the study of depression. Goodwin (1974) has stressed that behavior therapy can "produce an enduring chemical change in the brain" (p. 241) and, conversely, drug therapy or treatment can produce a change in behavior. Therefore, cause and effect can be viewed from two radically different perspectives. The discussion at hand will take the perspective of biological theories of depression which focus primarily on genetics, neurochemistry, and endocrinology.

Genetic Theories

Genetic theories address a genetically-linked predisposition or inherent vulnerability to depression (Depue & Monroe, 1979; Winokur, 1972, 1973; Winokur & Clayton, 1967). Research that led to this theoretical position has relied on family studies, twin studies, and cross-rearing studies. Family studies have indicated that first degree relatives of diagnosed depressed individuals have a higher risk-factor in developing depression than is found in the general population (Klerman & Barrett, 1973). In a review of twin studies, Tsuang (1975) reports an "overall concordance rate for affective disorder in monozygotic pairs (MZ) is 76%, whereas in dizygotic pairs (DZ), the concordance rate is 19%" (p. 85). Cross-rearing studies that follow adopted high-risk children indicate a genetically transmitted vulnerability to depression (Kety, Rosenthal, Wender, Schulsinger, & Jacobson, 1975). While these findings generally receive empirical support (Depue & Monroe, 1979), Freden (1982) criticizes such studies' lack of "extensive longitudinal studies of patients, particularly prior to the depression" (p. 113). It is argued that the general lack of social factor controls, societal and cultural analysis, cross-referencing of biochemical, individual, and social components, and vagueness about precipitating factors render such findings insufficient to explain depression through genetics alone.

Of particular interest to the prevalence literature, genetics has looked at depression as a trait linked to the X-chromosome (Seiden, 1982). Since women have two X-chromosomes, it has been argued that women may be more susceptible to depression if that gene is dominant. Hammen (1982) reports that "the X-linked theory has received only mixed support" (p. 145). Seiden (1982) points out that this research is not only based on small samples of severely depressed inpatients, but tends to not consider other etiological factors or their interaction with genetic predisposition to depression. On the whole, it would seem that genetic theory indicates a possible understanding of some predisposition to exhibit depression, but it does not seem to explain the prevalence of depression in the general population or in women in particular.

Neurochemical Theories

Neurochemical theories of depression are particularly vulnerable to Goodwin's (1974) observation that changes in brain chemistry may be either cause or effect of depression. These theories have been generated by pharmacological treatment observations. It was noted that the use of reserpine as a treatment for hypertension produced depression (Goodwin & Bunney, 1971) by depleting serotonin and norepinephrine in the brain (Shore & Brodie, 1957). In addition, it was discovered that monoamine oxidase (MAO) produced mood elevations by raising brain amine levels thereby inhibiting their destruction and, consequently, MAO inhibitors were an effective treatment for depression (Goodwin, 1974). Another pharmacological intervention for depression was found when it was discovered that tricyclic antidepressants (originally used as tranquilizers) could block the reuptake of amines and functionally raise the amine levels at crucial neurotransmitted sites in the brain (Klerman & Weissman, 1980). Discoveries such as these led to neurochemical or amine theories which view depression as a deficit in brain neurotransmitter amines at crucial synaptic sites.

Neurochemical theories are not without their critics. As noted, Goodwin (1974) suggests that these findings could be the result of depression and may have limited implications for understanding depression. Klerman and Weissman (1980) suggest "that the chemical interactions and shifts during depression are extremely complex and that more careful research is necessary" (p. 67). Freden (1982) challenges biochemical hypotheses of depression on the basis of the cause-or-effect controversy and on the

lack of consideration of social or external events that may correlate with the depression. Personally, I object to this drug-related view of depression for three reasons: (1) the focus on symptoms and symptom removal diverts our attention from other possible causes of depression and the masking of symptoms may prohibit the depressed individual from recognizing external factors involved in precipitating and continuing their affective complaints; (2) these theories present a disease model that encourages drug-dependency and a fatalistic attitude regarding remission of the depression; and (3) because women are believed to be more susceptible to depression--whether or not that is born out in fact, they are at a higher risk for receiving drug treatment from physicians without appropriate consideration of their life-events and other contributing factors in the depression.

Endocrinological Theories

Endocrinological theories are particularly targeted at depression in women that has been associated with their menstrual cycle, the post-partum period of child-bearing, and menopause. Observations of depressive reactions to some oral contraceptives are also cited in this literature (Parry & Rush, 1978). At this point in time, there does not appear to be sufficient data that links female hormones and neurotransmitter substances affecting mood disturbances such as depression (Hammen, 1982), and existing studies have failed to demonstrate that such disturbances exist independent of situational and psychological factors (Goldzieher, Moses, Averkin, Scheel, & Taber, 1971). Moreover, these theories offer little to our understanding of depression in the general population and tend to perpetuate a sexist view of women. In addition, Hammen (1982) notes that depressions associated with postpartum, premenstrual, and oral-contraception are generally transitory states.

Psychological Theories

Psychological theories of depression are numerous and varied. In addition, they often overlap with each other and with sociological theories. In order to provide an overview of psychological thinking about depression particularly depression and women, the following brief discussions will be limited to psychoanalytic, behavioral, cognitive, self-in-relation, social learning, and existential approaches to depression

theory.

Psychoanalytic Theory

Psychoanalytic theory of depression centers around object loss and aggression or anger turned inward. Although the extensive literature on psychodynamic approaches to depression has been complicated by the introduction of personality and sociological research (Klerman & Weissman, 1980), "most psychoanalytic theories include in their formulations of depression extreme oral dependency, intense narcissistic needs, low self esteem, a severe and punishing superego, and feelings of guilt in relation to aggression turned inward" (Cox & Radloff, 1984, pp. 126-127). Oral dependency is related to fixation at the oral stage of development, birth to one or two years of age, due to frustrations of the ego. Narcissistic needs reflect frustration at some pre-genital stage of development when an individual is focused on self-love issues. Both oral dependency and narcissism are generally equated with the need for love and affection that was frustrated at some early stage of psychological development (Wetzel, 1984).

Low self-esteem, a severe and punishing superego, and feelings of guilt related to anger are best seen in Jacobson's (1971) object-relations theory of depression. Object loss may refer to a social event and the psychological process involved in the loss of a love object or the emotional withdrawal from such an object. These objects may be a relationship, a social role, a job, or anything that held particular value for the individual. Depression is differentiated from grief through the association of actual loss with grief and emotional loss with depression (Bibring, 1953). Wetzel (1984), in describing Jacobson's object-relations theory, describes how object loss affects self-esteem, the punishing superego, and feelings of guilt about aggressive impulses:

> Fear of abandonment and related fear of aggression against the needed and frustrating object lead to the denial of the object's frustrating and aggressive aspects, while denying their own negative aspects as well. When such denial fails, catastrophic self devaluation takes its place. At best the devaluation is partial and leads to hostile self-affirmation and increased, albeit premature, autonomy. At worst, the devaluation is total and encompasses an impoverishment of the self. In either case, both the idealized object and the corresponding intrapsychic object representation are lost. (p. 29)

Psychoanalytic theories of depression, in general, hold that depression has its roots in conflict or frustration at the early oral and anal psychosexual states of development. In addition, it has been hypothesized that these conflicts and frustrations are related to the loss, particularly emotional loss, of a needed object, thereby predisposing that individual to depression whenever an emotional loss is experienced (Jacobson, 1971). The formulations found in psychoanalytic theories of depression are somewhat difficult to investigate, consequently there is only limited empirical support for some of these formulations (Chodoff, 1972, 1974). Prevalence literature has noted the correlation between psychoanalytic descriptions of the feminine personality and the depressed personality, but takes exception to this similarity since the feminine personality develops at a later psychosexual stage than the depressed personality. Personally, I take exception to any description of a normal feminine personality as narcissistic, masochistic, having low self-esteem, being excessively dependent, and as having inhibited hostility (Cox & Radloff, 1984). It has been suggested that "until further evidence is generated, the psychodynamic theories must be regarded as stimulating but still tentative and not fully established" (Klerman & Weissman, 1980, p. 66).

Behavioral Theories

Behavioral theories of depression often overlap with cognitive theories; however, strict behaviorists view depression as the result of the law of reinforcement. "Depression is considered to be a learned response, the result of a 'low rate of response-contingent reinforcement'," (Wetzel, 1984, pp. 179-180). Ferster (1958) suggested that depression resulted when an individual did not have or express behaviors that would elicit positive reinforcement. Lazarus (1968) hypothesized that depressed persons' behavior, although originally intended to elicit attention, support, and nurturance, causes others to become frustrated and angry, yet inhibited in the expression of that anger. As a result, others and the positive reinforcement they offer withdraw and become inaccessible to the depressed person. Both Ferster (1958) and Lazarus (1968) present models that focus on the individual's behavior or repertoire of behaviors as the predictor of low rates of positive reinforcement and the resulting depression.

Social reinforcement. Lewinsohn (1974), using a social reinforcement model, observed that the low rate of response-contingent, positive reinforcement in the environment predicts certain aspects of depressive behavior. According to Lewinsohn's (1974) model, depression can be "predicted by three factors: potentially reinforcing events in the environment, and the instrumental behavior of the individual" (Klerman & Weissman, 1980, p. 69). Lewinsohn's (1974) social reinforcement theory focuses on both behavior and environment and presents a cyclic aspect of depression: a lack of rewards leads to passivity and fewer initiated responses which, in turn, leads to fewer rewards or positive reinforcement. This is further complicated when "the 'sick role' or certain depressive behaviors may be positively reinforced" (Cox & Radloff, 1984, p. 128) and, therefore, perpetuate the depression.

Learned helplessness. Seligman's (1975) learned helplessness theory has been discussed in both behavioral and cognitive literature, so it may be considered a cognitive-behavioral theory that has been used to explain depression. Learned helplessness grew from animal research which demonstrated that uncontrollable traumatic events could interfere with adaptive behavior. Learned helplessness theory focuses on the role of control over one's environment and life events as the predictor of depression: one feels helpless in controlling traumatic events or unrewarding environments and loses the ability to act adaptively to effectively avoid, escape, or change that condition. In subsequent learned helplessness research with humans, it has been proposed that people learn to be helpless in three ways: (1) overprotection or lack of opportunity to learn mastery in the environment, (2) past trauma experience where control over negative events is absent, and (3) no previous experience of failure. Each of these is related in some way to the cause of learned helplessness--continuous response-reinforcement independence--and depression.

Behavioral theories and the learned helplessness theory are often cited in the prevalence literature. It is argued that women may exhibit depression more than men based on both their learned behaviors and their environments. "One could argue that, rather than there being actual social and economic discrimination against women, women are socialized to be unassertive, dependent, passive, or helpless, all of which behaviors lead to depression rather than action under stress" (Rothblum, 1983, p. 88). "Women

who are trained to be submissive, dependent, and passive will not feel they have much control over their environment, so that the perception of no relationship between their efforts and any significant results in their lives would result in the feeling of helplessness" (Rothblum, 1983, p. 89).

Cognitive Theory

Cognitive theories of depression rely heavily on the work of Aaron Beck (1967, 1974). The basis of Beck's (1974) model is that the same experience can affect two people differently and part of this difference may be attributed to their cognitions of the event. Thinking as well as behavior become part of cognitive theories of depression. In the early 1960's, Beck (1963, 1964, 1967) formulated his systematic theory of the origins of depression from data collected through interviews with his depressed clients. Three major concepts are used to account for depression (Beck, Rush, Shaw, & Emery, 1979): (1) the cognitive triad, (2) schemas, and (3) cognitive errors.

The cognitive triad consists of negativistic ideas and attitudes about self, the external world, and the future. Depressives are thought to hold a pervasive self-view of worthlessness, defectiveness, or inadequacy. This view seems to be compounded when they compare themselves to others. In many instances, this appears to reach levels of self-hatred (Levitt, Lubin, & Brooks, 1983). Depressed persons view the external world as a burden demanding more than they can handle. They feel helpless and hopeless in a world that offers nothing but defeat. In addition, depressives expect that nothing will occur in the future to change their condition.

Schemas are cognitive processes used by all people to organize and predict experience. Depressed persons hold stable, long-standing schemas that promote a pejorative view of themselves. These schemas are consistent and independent of what actually occurs in their environment (Levitt, Lubin, & Brooks, 1983).

Cognitive errors allow the person vulnerable to depression to maintain these schemas. Six cognitive errors identified and defined are: (1) arbitrary inference, (2) selective abstraction, (3) overgeneralization, (4) magnification and minimization, (5) personalization, and (6) absolutistic, dichotomous thinking (Beck, Rush, Shaw, & Emery, 1979). Levitt, Lubin, and Brooks (1983) describe these six cognitive errors as follows:

Arbitrary inference refers to the process of drawing a specific conclusion in

> the absence of evidence to support the conclusion. . . . Selective abstraction consists of focusing on a detail taken out of context, ignoring other more salient features. . . . Overgeneralization refers to the pattern of drawing a general rule or conclusion on the basis of one or more isolated incidents and applying the concept across the board to related and unrelated situations. Magnification and minimization are reflected in errors in evaluating the significance or magnitude of an event . . . to constitute a distortion. Personalization refers to the patient's proclivity to relate external events to himself when there is no basis for making such a connection. Absolutistic dichotomous thinking is manifested in the tendency to place all experiences in one of two opposite categories. . . . (p. 90)

The premise of Beck's (1974) theory of depression is that negative cognitions in the form of the cognitive triad, schemas, and cognitive errors are the cause of depression as well as symptoms of depression. While behavioral theory looks at behavior as cause and symptom of depression, cognitive theory looks at thinking in this regard. Cognitive-behavioral theory, where Beck (1974) and Seligman (1975) are often cited as examples, looks at both behavior and thinking as interactive parts of depression. Within the context of cognitive-behavior theory, Beck (1974) seems to emphasize thinking more than behavior and Seligman (1975) seems to emphasize behavior more than thinking.

Prevalence literature lends some support to Beck's (1967) statement that women may be predisposed to depression as a result of their socialization. The cognitive triad of negativistic ideas and attitudes is validated by many women's experiences. It has been argued that cognitive-behavioral theories of depression have raised many of the same questions and observations as those concerned with socialization, sex roles, sexist attitudes, and discrimination (Ballou & Gabalac, 1985). A society that encourages women to be compliant rather than assertive, dependent rather than autonomous, and nurturing of others rather than one's self, establishes a predisposition in women to view themselves as worthless, view the world as a value system that leaves them helpless and hopeless, and the prospects for a change in their condition in the future rather dim. Similarly, such a socialization process could establish stable, long standing schemas that

promote a pejorative self-view. Beck's (1974) theory of depression states that the cognitions of the depressed person are distorted. However, if the observations concerning women's socialization and life-experience are true, a woman's cognitions may not be distorted. They may be realistic interpretations of her actual experience. It would seem that changing these cognitions is challenging the reality of the experiences that led to these cognitions. Women's experience would seem to be a central factor in depression according to behavioral and cognitive-behavioral theories.

Self-in-Relation Theory

Self-in-relation is a theory of personality development in women that was developed at the Stone Center for Developmental Services and Studies at Wellesley College (Miller, 1984; Surrey, 1984). While this theory does not address depression in the general population, implications for depression in women are addressed by Kaplan (1984). Both the theory and its implications for depression focus on the development of underlying personality structure within the social context experienced by women. The difference between this focus and existing theories is presented in the following statement by Kaplan (1984):

> We are arguing that while existing theories posit some form of autonomy or separation as the developmental path, women's core self-structure, or their primary motivational thrust concerns growth within relationship, or what we call the "self-in-relation." By relation we mean much more than is indicated in interpersonal or object-relations theories. . . . What we are emphasizing, in contrast to these theories, are the key aspects of attaining a capacity to be attuned to the affect of others, understanding and being understood by the other and thus participating in the development of others. Thus, relationship is a two-way interaction, at its best a mutual process wherein both parties feel enhanced and empowered through their empathic connection with the other. (p. 3)

Depression in women is examined by comparing this theory to four key elements of depression: (1) the experience and vulnerability to loss; (2) inhibition of anger and aggression; (3) inhibition of assertiveness of action; and, (4) low self-esteem.

Vulnerability to loss is presented as a possible constant feeling state in women. Women's attributes in relational capacities are devalued in western society; thus, leaving them with a sense of loss in power and possibly a sense of loss of self (Miller, 1976). "It is the loss of confirmation of their core self-structure as one which can facilitate reciprocity and affective connection in relationships" (Kaplan, 1984, p. 5). If this underlying state of felt loss is a constant in women's experience, any further or accumulated loss can exacerbate this pattern and result in clinical depression.

Inhibition of anger and aggression is viewed as a common element of women's personality and exaggerated in depressed women (Miller, 1983; Kaplan, 1984). While depressed women may be aware of and possibly be in touch with their anger, they inhibit expression of that anger for two reasons: (1) "women experience their anger not as a valid sign of strength, but rather as a confirmation of their bad and worthless self" (Kaplan, 1984, p. 7), and (2) women fear that expression of their anger will be destructive to significant relationships. Miller (1983) suggests that depression in women may be associated with a cycle that allows anger to accumulate and become exaggerated. This cycle begins with anger which is constricted in its expression for cultural and relational reasons which leads to a sense of powerlessness and constricted expression of self which leads to further anger, further inhibition, further sense of powerlessness, and so on. The end result is exaggerated anger, exaggerated inhibition of anger and aggression, and depression.

Inhibition of action or assertiveness tends to be selective for women, i.e., actions and assertiveness that enhance or support significant others are less inhibited than actions and assertiveness that further one's personal goals. Once again this is exaggerated for depressed women:

> For women who become depressed, the profound fear of major disruption of relational ties and concomitant basic threat to the integrity and authenticity of the core self-structure can constrict seriously a large range of activities and modes of expression. . . . There is a distinct selective inhibition which applies strongly to actions which further one's own goals, and not nearly as strongly, if at all, to actions which support or enhance someone else. (Kaplan, 1984, p. 6)

It is important to note that western society reinforces this selectivity of actions in women, i.e., women are expected to nurture and support others. Yet, this same society views it as pathological when it is exaggerated. Therefore, it may be proposed that society generates mild forms of pathology in all women through its sex role definitions and values.

Low self-esteem may be concomitant to the above three elements of depression and personality development in women. It is difficult to determine the cause and effect relationship of self-esteem to vulnerability to loss, inhibition of anger, and inhibition of action and assertiveness. There is reason to believe that culturally defined sex roles and values assigned to those roles generate some level of low self-esteem in all women. "For women in general, there lingers a certain sense of inadequacy (especially when they measure themselves against culturally valued masculine norms) which is directly translated into lowered self-esteem" (Kaplan, 1984, p. 8). Depressed women present an extreme of this lowered self-esteem, but it is difficult to know if this is the result of their experiences and personality development or the cause of it.

In general, Kaplan (1984) states that these four key elements in depression exist to some degree in all women, but are exacerbated in clinically depressed women. In other words, depression, in some form, may be the feminine condition or norm. As such, it is not viewed as pathological. When the symptoms of this condition reach extremes, the woman is labelled depressed.

Self-in-relation theory and its implications for depression were developed by women about women and from that viewpoint it is not only gender-specific, but rare. This theory's focus on the importance of self-esteem and the cultural impact on women that diminishes their self-esteem reinforces Beck's (1967) suggestion that women may be predisposed to depression through their socialization. Both would seem to indicate that until society and our culture values women in a way that women can also value themselves, we may not have much hope of preventing depression in women. It should be noted, however, that Kaplan's (1984) theory of depression is fairly new and has yet to be supported by research. In addition, self-in-relation theory in general could be criticized as failing to present a model of healthy personality development. Therefore, at this time the self-in-relation theory of depression in women may be considered

interesting and stimulating, but in need of further development and research.

Social Learning Theory

Social learning theories have had some implications for depression and the socialization processes noted in behavioral, cognitive-behavioral, and self-in-relation theories. Early research by Spitz (1945) observed that depression could result from early separation from the mother in the second half of the first year of life. Harlow, Harlow, and Suomi (1971), in their study of attachment in monkeys, noted depression symptoms when there was a disruption of a significant attachment bond. Ullman and Krasner (1969) proposed that faulty social learning and the maintenance of depressive symptomotology by rewards for adopting a "sick role" were components of depression. Baumrind (1980) presents social reinforcement as an important factor in women's socialization that leads to a deficit in autonomy and a corresponding development of many of the symptoms of depression noted in previously discussed theories:

> This diffuse personal identification of daughter with mother encourages the merging of the self with the perspective of the other and a consequent diffidence about asserting one's own perspective which can place women at a competitive disadvantage with men. In view of society's tolerance of female dependence throughout the life cycle, a gender identity defined by merging rather than by autonomy may also keep a daughter tied to the security of her home and the person of her mother, so that she fails to develop her full power and cognitive competence. (p. 643)

Social learning theories appear to support various aspects of other theories of depression. Spitz's (1945) and Harlow, Harlow, and Suomi's (1971) observations of early separation from the mother and a disruption in a significant attachment bond as elements of depression appear to lend some support to psychoanalytic theories of depression. Ullman and Krasner's (1969) research appears to support Lewinsohn's (1974) social reinforcement theory of depression. Baumrind's (1980) social reinforcement hypothesis lends support to depression theories presented by Beck (1967), Seligman (1975), and Kaplan (1984) as they pertain to depression in women. Social learning and sociological theories have implications for gender differences in the cause and expression of depression and are often cited in the literature that seeks to

explain the prevalence of depression in women (Hammen, 1982).

Existential Theory

Existential theories of depression look within individuals, particularly their processes of growth, individuality, and self-determination. Existentialists focus on the individuals' representational reality, their interpretation of internal and external events and environment, as a key element in understanding depression (Rush & Giles, 1982, p. 147). Wetzel (1984) describes the existential perspective of depression as follows:

> Existentialists view depression as the result of alienation from the authentic self, as well as of alienation from other human beings. Playing out social roles, motivated to belong and not to be "different," individuals lose touch with those qualities that make them truly unique and special. Their authentic qualities, a synthesis of attributes that are unprecedented and never to recur, are often hidden from themselves, having been suppressed for so long. . . . Factors that may predispose a person to feelings of alienation and inauthenticity may begin in childhood. . . . people learn to deny their very existence early in life. Estranged from themselves, their task is to rediscover their true nature if they are to confront depression and transcend it. (p. 216)

Depression is described by existentialists as "the absence of creative energy, or a blocking of the way of the spirit--or both" (Wetzel, 1984, p. 217).

One existential theory of depression is presented by Becker (1962). Becker (1962) presents a multidisciplinary theory that derives its concepts from various theories and traditions (Freden, 1982). When one feels control over her actions, self-esteem is unaltered by temporary disturbances. Therefore, a "strong and stable awareness of self-worth is a powerful element in the defence against depression" (Freden, 1982, p. 7). Within this framework, Becker (1962) stresses the importance of patterns of action. He suggests that rigid or limited action patterns can lead to depression, while access to a broad range of possible actions when faced with difficult situations can avoid depression. It is proposed that while people can and do change through social interactions and communication, the depressed person is stuck for a time with her low self-esteem, limited range of actions, and rigid action patterns (Freden, 1982).

Freden (1982) presents eight factors, according to Becker (1962), that predispose a person to depression: "(1) low self-esteem; (2) a negative change that affects the meanings which provide him with a secure and/or strong sense of self-esteem; (3) few meanings which are too strongly controlled; (4) few controlled actions; (5) rigid action patterns; (6) few significant relationships; (7) the societal setting provides a limited range of possible actions and/or of actions accessible to control; (8) society is changing fast" (pp. 152-153). Also important in Becker's (1962) theory is the assumption that there is a basic human striving to acquire self-esteem and avoid anxiety. These strivings can often be conflicting and difficult to balance. The predisposition to depression is seen in this lack of balance. When a person avoids anxiety at the expense of her self-esteem, demands stable and definite answers to difficult situations at the expense of her flexible and ready answers, and denies one's self a repertoire or variety of alternatives, that person will not be balanced and thus, predisposed to depression. Freden (1982) proposes an additional predisposing factor: one loses balance when one is geared more toward "pleasing others than to enriching his own needs and experiences" (p. 153).

One advantage of existential theories in general is that mental health criteria are not tied to conformity and adjustment to societal norms (Ballou & Gabalac, 1985). The disadvantage of this view of mental health is that the total responsibility for growth and development is placed on the individual with little consideration for the impact of social values and socialization. This criticism is particularly relevant to the literature on prevalence and gender-related perspectives of mental health and disorder. However, the same criticism has been directed toward Becker's (1962) theory by those interested in depression in the general population (Freden, 1982). In addition, Becker's (1962) theory of depression has been criticized as being unclear and tangled in its formulations and arguments, too bound up in action with only tentative attention to emotional dimensions such as goals, anxiety, and guilt, and in need of further research support (Freden, 1982).

Aside from these criticisms, existential theory of depression has several implications for understanding depression. First, existential theory stresses the importance of alienation from one's self and others as a factor in depression. It has been noted that conforming to social roles, regardless of gender, can contribute to this

alienation (Wetzel, 1984). Second, living creatively with flexible patterns of action and reaction to life's events promotes balance and enhances one's chances of avoiding or transcending depression (Becker, 1962). Finally, existentialists seem to suggest that it is not experience, but the interpretation of that experience that determines an individual's representational reality and it is that individual's reality that can help us to understand depression (Rush & Giles, 1982).

Sociological Theories

Sociological theories focus on the correlation between depression and certain demographic or social factors. Gender differences have also been addressed as they relate to prevalence of depression, illness behavior, and perception of stress. Many of these theories integrate sociological and psychological aspects of depression and have come to be known as psychosocial or sociopsychological theories. Because this study is primarily interested in women's experience of depression and because the literature of sociology is so expansive, the following discussion will be limited to an overview of stress and gender-related factors that have become associated with depression in women.

Stress

Stress, as a correlate of depression, has been investigated from several perspectives: demographic factors that produce stress for women, gender differences in the amount of stress experienced, and gender differences in the perception of stress.

Community surveys have indicated a relationship between depression symptoms and social stressors (Ilfeld, 1977). When depression is analyzed in terms of life stress factors that interact with vulnerability factors (Brown & Harris, 1978), "role-related social stressors . . . are associated with depressive symptomatology" (Hammen, 1982, p. 146). Some of these social demographics that are related to stress are marital status, socioeconomic status, parenthood, and employment.

Marital status seems to affect men and women differently. Several research studies have shown that married men are less vulnerable to depression than never-married men, while married women are more vulnerable to depression than

never-married women (Gove, 1972; Gove & Tudor, 1973; Radloff, 1975; Radloff & Rae, 1979). In addition, never-married women and men are approximately equal in depression rates (Radloff, 1975). It has also been noted that more marital problems are experienced by depressed married women than non-depressed married women (Bullock, Siegel, Weissman, & Paykel, 1972). Brown and Harris (1978) proposed that vulnerability to depression in married women is associated with five factors: (1) lack of intimate relations with spouse, (2) loss of mother before age 11, (3) having three or more young children at home, (4) lack of full or part-time employment, and (5) working class background. In a review of the literature on marital status and depression, Al-Issa (1982) concluded that "mental illness could be the result of marital status as well as the cause of it" (p. 88).

In regard to socioeconomic factors in depression, the literature is divided in its findings. Belle (1980) concluded a positive correlation between low-income and disadvantaged groups and depression on the basis of the high incidence of these groups in facility use and treatment for psychiatric conditions. Levitt, Lubin, and Brooks (1983) reported a curvilinear correlation between income and depression, but no relationship between social class and depression. Other research seems to indicate a negative or no association between socioeconomic status and depression (Hollingshead & Redlich, 1958). While these conflicting findings may indicate interaction between other variables and socioeconomic status, more research is necessary before we can draw any conclusions regarding the socioeconomic factor in depression.

Parenthood has been suggested as a factor in depression. Brown and Harris (1978) indicated that having small children at home was one of five factors associated with depression in married women. Paerlin and Johnson (1977) found that single parents are most often women and that these single mothers, particularly when they had several children at home, were at a high risk of experiencing stress and depression. Belle (1980) reported similar findings for women who were sole heads of families. It has also been noted that contrary to the previously held belief that women become depressed when their children leave home (empty nest syndrome), mother's depression appears to diminish at this time (Radloff, 1980).

The relationship between employment and depression is complex and relatively unclear. It seems that unemployed men are more susceptible to depression than women unemployed outside the home (Bradburn, 1969; Radloff, 1975). In reviews of the literature on employment factors in depression, Rothblum (1983) concludes, with caution, that "the evidence seems clear that employment generally has a protective effect for depression" (p. 99) in women, while Al-Issa (1982) concludes that the findings are inconsistent, and Goldman and Ravid (1980) find the evidence inconclusive.

In addition to these demographic factors that are thought to stress women and predispose them to depression, the amount of stress experienced has been researched for gender differences. It has been hypothesized that "men and women may be equally depressed in response to life stresses, but women experience more of the stress events" (Hammen, 1982, p. 146) that precipitate depression. Using a community survey, Radloff (1975; 1980; Radloff & Rae, 1979) found that women were exposed to more stressors than men, but women continued to have higher depression scores when these differences were statistically controlled indicating the presence of other causal factors. Other studies using life-change units have reported no significant difference in the amount of stress between genders (Markush & Favero, 1974; Sarason, Johnson, & Siegel, 1978; Steele, 1978; Uhlenhuth, Lipman, Balter, & Stern, 1974). However, it has been argued that life event schedules commonly used in such research tend to underrepresent the events that women find stressful (Makosky, 1980). Therefore, one may conclude that the amount of depression predisposing stress in a woman's life is related to her perception of events as stressful.

It has been suggested that there is a gender difference in the way men and women perceive the stressfulness of events. Horowitz, Schaefer, Hiroto, Wilner, and Levin (1977) presented a list from a standard life event questionnaire to men and women and found that women's ratings of the events as stressful was higher than men's. Women have also been found to indicate a higher probability of depression following certain events than men (Parker, 1979). This was particularly true of loss of self-esteem, support and relational problems (Hammen, 1982). It is also argued that women's socialization to value relationships increases the probability that they would find interpersonal difficulties stressful and depression producing (Rothblum, 1983).

Regarding stress and depression in women, Hammen (1982) concludes the following:

> In the absence of further research, the implications of such results are hard to establish. For instance, it is unclear whether women differ from men in certain coping capabilities or supports, thus rendering them more vulnerable to experiencing distress than men, or whether women's stressors, if objectively quantified, would be found to be greater than men's. An additional alternative is, of course, that women are freer in the expression of their distress or demoralization over stressful events and circumstances than men are. (p. 147)

Gender Related Factors

Sociological or psychosocial theories of depression often look at gender-related factors associated with depression. Some of these have been noted in the discussion of stress through consideration of gender differences in type, amount, reaction to, and perception of stress as it is associated with depression. In addition, sociologists have addressed gender-related factors in depression such as differences in the way psychological distress is expressed, the way depression is expressed, the way depression is defined and diagnosed, and the effect of sex-role stereotyping. There is also a body of feminist literature that addresses the oppression of women which has implications for depression in women; however, the influence of feminist thinking is evident in the following literature critique and discussed more extensively in the following chapter on methodology.

There appear to be gender-related differences in vocabularies of distress (Dohrenwend & Dohrenwend, 1974). It is suggested that women are more willing to communicate distress through health-seeking behavior and identify their distress as depression (Rothblum, 1983; Seiden, 1982). "Women may be more likely to regard depression as one of the expected illnesses of life and seek clinical help" (Seiden, 1982, p. 391). Men may communicate distress through aggression or alcoholism or seek help for stress, particularly job-related stress (Lemay, 1980; Seiden, 1982). There is also some indication that men would avoid seeking help for psychological distress, especially depression, due to sex-role stereotyping restraints and conflicts (Dohrenwend & Dohrenwend, 1969; Rothblum, 1983; Wetzel, 1984). These differences have been

investigated and cited as possible artifacts that contribute to the preponderance of women in depression statistics (Dohrenwend & Dohrenwend, 1974; Weissman & Paykel, 1974).

Closely related to gender differences in vocabularies of distress are gender differences in the expression of depression. Gender differences in depression may not be a matter of differences in the factors in men and women's lives that provoke depression, but rather that "each sex tends to learn a different style with which it reacts to whatever factors produce psychological disorder" (Dohrenwend & Dohrenwend, 1969, p. 24). Sex-role stereotypes encourage men to take action (Freden, 1982) and "make more effective use of coping mechanisms" (Rothblum, 1983, p. 103) in the face of stressful life events. Women tend to be passive (Freden, 1982) and "are poorly trained to cope with disruptive life events" (Rothblum, 1983, p. 103). In addition to differences in help-seeking behavior, women tend to report more social and expressive symptoms of depression than men do (Rothblum, 1982). It may be that men mask depression through aggression, alcoholism, and job-related stress and, thus, confound the findings that report a higher incidence of depression in women than men (Lemay, 1980; Seiden, 1982). It may be that the more a person views depression as a weakness or unacceptable behavior, the more likely that person will express that depression in a socially and personally acceptable behavior. It has been noted that depression symptomotology may be more characteristic of women's sex-role stereotype than men's (Rothblum, 1983; Seiden, 1982; Wetzel, 1984). Therefore, it seems that sex-role stereotypes are an important factor in the preponderance of women in depression statistics. Moreover, it indicates the importance of sex-role stereotyping in the sociological view of depression in both sexes.

A stereotype is "a rigid, biased perception of an object, animal, individual, or group. . . . a uniform, inflexible mode of behavior" (Chaplin, 1975, pp. 514-515). Sex-role stereotypes are perceptions or beliefs ascribed to men and women (Rothblum, 1983). It has been proposed that the rigidity of these stereotypes predisposes both men and women to depression (Becker, 1962; Freden, 1982; Rothblum, 1983). This may be true for both those who restrict themselves to the constraints of the stereotype (Rothblum, 1983) and those who rebel against them (Freden, 1982; Miller, 1984). Self

perception and sense of worth is often tied to sex-role perception and the value given that sex-role. As was noted in previous discussions, negative self-perception and low self-esteem are associated with depression. Research has shown that sex-role stereotypes contribute significantly to low self-esteem in both sexes (Cosentino & Heilbrun, 1964; Emmerich, 1959; Gall, 1969; Harford, Willis, & Deabler, 1967; Mussin, 1962; Sears, 1970).

Several social scientists have addressed the effect of stereotyping on women's depression (Bernard, 1972; Chesler, 1971; Gove & Tudor, 1973; Hammen, 1982; Rothblum, 1983). They argue that women's restricted, comparatively frustrating, and less rewarding social roles "predispose them to various forms of psychological maladjustment as expressions of their discontent and deprivation" (Hammen, 1982, p. 145). Miller (1984) states that inequality between the sexes is socially ascribed at birth and that women's subordinate status can have a profound and intense influence on women psychologically. In a review of the literature on sex-roles and depression in women, Hammen (1982) presents the following conclusion:

> A growing body of research on possible linkages between women's roles (e.g., traditional and nontraditional roles of women and men, dual roles for women) and depression has yielded complex and sometimes contradictory results and conclusions (Aneshensel, Frerichs, & Clark, 1981; Radloff, 1975; Radloff & Rae, 1979; Rosenfield, 1980; Rothblum, in press). Whether women show an excess of depression compared with men in similar role situations or whether the sexes are similar under similar circumstances remains unclear at this time. (p. 146)

To some extent I find myself in agreement with Hammen (1982)--the literature on gender-related factors, including stereotyping, is complex and sometimes contradictory. However, it seems to reflect another instance where further research is necessary before we can accept or reject the hypothesis that sex-role stereotypes are factors in depression or the hypothesis that there are sex differences in depression.

D. Summary

This literature critique has represented my sojourn in the Land-of-What-Is-Said. As I prepare to set sail to the Land-of-Experience, it may be appropriate to acknowledge the alterations in understanding (along with the questions) that accompany me on this voyage.

Although I had hoped to come away with a simple, definitive answer, I found that the inhabitants of this land were in a definitional dilemma that was a symptom of their symptomotology. This led me to several conclusions regarding defining depression. First, symptoms are too numerous and varied to provide a definition of depression. Second, symptoms can be either cause or effect of depression. Third, symptoms tend to objectify depression and take our attention away from the individual who is having the experience. Fourth, symptoms are generally the basis of most popular depression inventories, so test scores present the same problems in defining depression as noted above. Fifth, symptoms rely heavily on self-report. Finally, given the definitional dilemma, depression can be anything someone says it is. Therefore, it is important to know how someone defines and describes depression when reading the current literature on depression or talking to someone who volunteers for a study of depression.

Because I am a woman, I was particularly interested in what the inhabitants had to say about the prevalence of depression in the general population and women. Even though I couldn't find a consensus in their prevalence statistics or consistency in actual ratios for the sexes, they seemed to generally agree that women are the largest portion of the population wearing the label "depression" and that more women than men were being targeted and treated for depression. This led me to the conclusion that my future questions about depression would best be directed to women who have lived in the land of that experience. These would be the women who would define and describe depression and help me to understand depression from the perspective of those who comprise the largest portion of the population who have worn the label "depression."

Those inhabitants who talked theory were often in conflict with each other as they offered the multiplicity and diversity of thinking and research that they associated with understanding depression. Biological theorists looked inside the depressed person for physical and medical components of depression. Genetic biologists presented

research that indicates a hereditary predisposition for some types of depression in some people, but their research was criticized and found to be tentative and inconclusive. Neurochemists talked about neurotransmitter substances as the fundamental problem in depression, but they couldn't determine whether this was causal or effectual and their critics challenged them for their limited focus and simple answer to an extremely complex area of chemical interaction. One critic suggested that neurochemical findings may have limited implications for understanding depression (Goodwin, 1974). Endocrinologists tried to relate depression to women's menstrual cycle, oral contraceptive use, and child bearing, but their critics pointed to the transitory state of these depressions and their failure to demonstrate that these conditions existed separate from external factors. In addition to their criticism of each other, I voiced concern over biological theories' preoccupation with treatment by drug therapy (particularly neurochemical approaches to depression) as diverting attention from other possible causes of depression, masking depression symptoms, presenting a disease model of depression that encouraged drug-dependency and a fatalistic attitude, and as putting women at higher risk than men for receiving this kind of diagnosis and treatment.

Psychological theories of depression tend to look at external events and environment as important factors associated with depression. Even within this framework, conflicts and disagreements were noted. Each area of psychology--psychoanalytic, behavioral, cognitive, self-in-relation, and existential--had their own perspective on depression, particularly depression in women, and while they each offered some insight into understanding depression, each had their critics. The same was found in conversations (literature critique) with sociological theorists. I found myself leaving the theorists with more confusion than clarity.

The issues, controversies, and resulting confusion that emerge from a literature review led me to question what we know about depression. The inhabitants of this Land-of-What-Is-Said have contributed greatly to our understanding of depression, yet, I found that all of this knowledge still left me wanting to know. It seemed that depression had become objectified from the experience, particularly the experience of women. Perhaps it was that distance between the experience of depression and what we know about depression that left me still wanting to know. Gadamer (1986) noted that

experience "has been subjected to an epistemological schematisation that, for me, diminishes its original meaning" (p. 310). Somehow, our knowledge of depression may have become separated from its manifestation in life. "That it is life that manifests itself in experience means only that it is the ultimate to which we come back" (Gadamer, 1986, p. 60).

So it is, that I find myself preparing to sail back to the Land-of-Experience to understand depression, particularly depression in women, with a further understanding that depression may never be understood for all people in all situations, but that it may be only understood as it is individually expressed, individually defined and described, and by the meaning such an experience holds for the individual--in this case, for the women in this study.

While traversing the gulf between the Land-of-What-Is-Said and the Land-of-Experience, I found myself sometimes compelled by winds in the sails and other times, drifting to ponder the relevance of the literature on depression and the literature on methodology. Both had something to say about the alterations in understanding depression that had occurred during my sojourn abroad.

III. METHODOLOGY

Once a research question has been identified, the researcher is faced with the task of how best to bring an answer to light. Primarily, this is the search for a method of inquiry which will not only be appropriate to all aspects of the inquiry, but be capable of producing an answer of considerable integrity. Such a search does not exist in a vacuum. It has been well documented that the choice of research method, its conceptual framework and techniques of data collection and analysis are not neutral or value-free (Eichler, 1985; Fee, 1983; Malmo, 1983; Messing, 1983; Stanley & Wise, 1983). The researcher's values and beliefs are inherently a part of the whole research process, including the method of inquiry. Therefore, it seems imperative that researchers not only admit that their research is not value-free, but state as clearly as possible what values shape the perspective and choices they make throughout all phases of their investigation. To this end, the following discussion of methodology will focus on two major considerations which determined the research method of this study and in which my values and beliefs are most apparent: (1) the character of the question, and (2) working with women in research. The summary will illustrate how these two considerations were integrated to produce this study's research method.

A. Character of the Question

The character of a thing is that which distinguishes it from other things. In this case, the language of the question indicates its distinguishing characteristics: What does the experience of depression mean to women who have experienced this state of being-in-the-world? "What" questions generally require descriptions of something and indicate a descriptive quality to the method of inquiry. Therefore, the search for an appropriate method of inquiry begins with a focus on descriptive methods. Next, the words, "experience" and "being-in-the-world," indicate what it is that needs to be described. Any description of life-worlds immediately draws the researcher's attention to phenomenological methods of inquiry. However, this research question seeks more than a description of the lived-world of depression. It asks for a description of the meaning that experience holds for women now that they reflect back on it. Therefore, the character of this research question requires a method of inquiry that is descriptive,

phenomenological, reflective, and sensitive to uncovering meaning. These distinguishing characteristics led to an exploration of hermeneutics as a potentially appropriate method of study.

Hermeneutics

Hermeneutics comes "from the Greek **hermeneutikos**, 'related to explaining'; 'explaining' is used here in the sense of 'clarifying,' of rendering the obscure plain, the unclear clear" (Bauman, 1978, p. 7). During the sixteenth century, hermeneutics emerged within the discipline of philology which was concerned with the origins and laws of language. During the Catholic-Protestant disagreements over the true meaning of biblical texts and the authentic version of the Bible, hermeneutics became the mode of methodical scholarship employed to critique historical documents for their authenticity and true meaning (Bauman, 1978). With these beginnings, hermeneutics became associated with the interpretation of historical texts in which there existed a "consciousness of distance, and the problems it implies for correct understanding" (Dallmayr & McCarthy, 1977). Thus, we find hermeneutics expanding its sphere of influence into areas such as jurisprudence and the humanities. Renaissance humanists were concerned with understanding classical texts and hermeneutics offered a powerful tool for reaching this understanding, but hermeneutics continued expanding its sphere of influence and became a challenge to the social sciences.

Bauman (1978) suggests that the challenge to social sciences occurred when hermeneutics changed from a tool to solve problems to a tool that created problems:

> As long as the task of "clarifying" which hermeneutics set for itself was seen as, above all, a search for the original, undistorted message of written sources, hermeneutics was rightly viewed simply as a tool, however powerful and indispensable. A tool helps to solve problems; it does not create them. By the end of the eighteenth century, however, a fateful shift took place. The philosophical reflection on the activity and results of hermeneutics moved beyond the mere critique of texts and began to ask difficult questions about the nature and the objectives of historical knowledge as such; indeed, of social knowledge in general. (p. 8)

This shift did not occur in hermeneutics alone. The use of hermeneutics shifted as it expanded its sphere of influence into disciplines other than biblical exegesis or philological methodology and reflected the shifts in thinking within those disciplines, particularly the philosophical areas of the humanities.

Tracing the evolution of hermeneutics does not seem germaine to this study, but understanding current hermeneutical thinking has implications for its methodology. Palmer (1969) presents current hermeneutical thinking as polarized between the traditions of Dilthey and Schleiermacher on one hand and the traditions of Heidegger and Gadamer on the other. Those who follow Dilthey and Schleiermacher propose the possibility of objective, valid knowledge through a hermeneutics with methodological principles of interpretation. This model presents the autonomy of the object of interpretation and suggests a contemplative model of scientific objectivity (Palmer, 1969). Such a model has obvious conflicts with the discussion of feminist views of objectivity presented later in this chapter and was set aside from any further consideration as a model for the present study. It was in the traditions of Heidegger and Gadamer, who present "hermeneutics as a philosophical exploration of the character and requisite conditions for all understanding" (Palmer, 1969, p. 46), that this study found the methods of hermeneutics an appropriate method of inquiry.

In Wahrheit und Methode: Grundzuge einer philosophischen Hermeneutiks (1960), Gadamer presented his development of the "consequences of phenomenology, and in particular Heidegger's thought, for hermeneutical theory" (Palmer, 1969). In this work, Gadamer presents a view of understanding as an ontological process in humans (Palmer, 1969), i.e., it is the nature of being human to understand or come to an understanding. As a human, I came to an understanding of Gadamer's philosophical hermeneutics through a recent publication of an English translation of this work (Gadamer, 1986). It is that understanding which represents the methodological foundation of this study and is discussed below.

According to Gadamer (1986), the concept of the question is important to the hermeneutical situation. The question arises from experience and is part of the "logical structure of openness, which characterizes hermeneutical consciousness" (p. 325). This questioning and openness are to "find their fulfilment in a radical negativity: the

knowledge of not knowing" (p. 325). Thus, one approaches a hermeneutic situation with a knowledge of not knowing both of experience through a recognition that something is different than we first thought and an openness to knowing it as it presents itself to us in the hermeneutical experience.

The hermeneutical experience is an "I" and "Thou" relationship. The "Thou" is the tradition of language transmitted in the text.[2] The text is not an object separate from us, but rather something that stands in relationship to us:

> All reading involves application, so that a person reading a text is himself part of the meaning he apprehends. He belongs to the text that he is reading. . . . He can, indeed he must, accept the fact that future generations will understand differently what he has read in a text. (Gadamer, 1986, p. 304)[3]

It follows that any understanding achieved in a hermeneutical experience is necessarily temporal in that even the same reader returning to the same text at a latter point in time must once again be open to gaining a new understanding. This temporal state of understanding appears to involve two interacting factors: the reader and the text.

The reader comes to the text with a concern for the same subject and, therefore, has some preconceptions or fore-understanding of the subject. It is the reader's fore-understanding that plays a large part in the interpretation of the text and that is at risk in the hermeneutic encounter. While positivist-based, empirical science strives to eliminate these prejudices in their striving for understanding, Gadamer suggests these preconceptions are vital to the communication of a hermeneutical encounter:

> To try to eliminate one's own concepts in interpretation is not only impossible, but manifestly absurd. To interpret means precisely to use one's own preconceptions so that the meaning of the text can really be made to speak to us. (p. 358)

These prejudices or preconceptions, rather than being denied, are made clear and put at

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[2]Gadamer appears to refer to "text" as written language to be read. This study takes "text" to mean anything transmitted through language. The meaning of "text," as I understand it and apply it to this study, is explicated in Chapter 4.

[3]Although Gadamer uses masculine language (e.g., he, himself, man) in this and other quotes cited in this study, my understanding of his hermeneutics is that it is not sexist in content or in its implications for this study.

risk of being changed or dismissed as a result of the encounter. During the hermeneutic encounter, the reader is asked to question her preconceptions to determine "the true prejudices, by which we understand, from the false ones by which we misunderstand" (Gadamer, 1986, p. 266).

> A person who is trying to understand a text has also to keep something at a distance, namely everything that suggests itself, on the basis of his own prejudices, as the meaning expected, as soon as it is rejected by the sense of the text itself. (Gadamer, 1986, p. 422)

Such a reader would contribute to the temporal state of a hermeneutical experience and of understanding and would explain why each reader at different points in time brings different preconceptions to the hermeneutic encounter with the text and will understand differently. Therefore, Gadamer advocates a reader or researcher who participates with openness rather than one who predicts from uninvolvement and he stands in opposition to any claim to universally valid truth.

The text, as the "Thou" in the relationship, must be helped to speak in the hermeneutic situation. While this may explain the text's contribution to the temporal state of understanding, it also presents the difficulty in hermeneutic experience: "the need to feel the objective claim of the text in its full otherness without, at the same time, making it a mere object for our subjectivity" (Palmer, 1969, p. 244). This difficulty is overcome when the reader acknowledges her own horizon, suspending the validity of her preconceptions, while remaining open to the horizon of the text. Thus, truth is said to emerge into being through "the full potentialities of the interpreter and text, the partners in the hermeneutical dialogue" (Palmer, 1969, p. 244).

Truth, here, is not conceived of as "fact" or as total. Truth is seen as inexhaustible and ambiguous. In the hermeneutical experience, truth emerges from an inexhaustible well through a dialectic grounded in negativity: the knowledge of not knowing. It is ambiguous in that what emerges for one reader may simultaneously cover up what may emerge for another reader. Thus, the inexhaustible fullness of truth may never emerge for any one reader at any one time. Truth remains open to interpretation as the reader remains open to the text and the text remains open to the reader's assistance in speaking.

In Gadamer's (1986) hermeneutics, dialectic "is the art of conducting a real conversation" (p. 330). It is the process of questioning and seeking the truth which Gadamer equates with the art of thinking.

> To conduct a conversation requires first of all that the partners to it do not talk at cross purposes. Hence its necessary structure is that of question and answer. . . . To conduct a conversation means to allow oneself to be conducted by the object to which the partners in the conversation are directed. (p. 330)

Conversations necessarily rely on language. Gadamer contends that language is inextricably bound to our experience of the world, the way we articulate that experience, and the way in which domains of experience begin to open up and achieve order. Therefore, in conversation we are not so much interested in the experience of language as interested in language as a way of understanding experience. "From language we learn that the topic is not some random self-contained object of discussion, independently of which the process of mutual understanding proceeds, but rather is the path and goal of mutual understanding itself" (Gadamer, 1986, p. 158). Thus, language and interpretation are more than means to an end--they are part of the "content of what is understood" (p. 359).

Dialectical hermeneutics may be conceived as a potentially never ending circle of understanding and questioning. We enter the circle with a question born of experience, the knowledge of not knowing, and certain preunderstandings that will direct the subsequent conversation. We proceed with openness to engage in conversation, an "I" and "Thou" relationship, with a text at the risk of these preunderstandings. It is understood that both partners in the conversation meet through and are directed by a common topic or object. This hermeneutic encounter is an experience that leads us to further questioning, interpretation, and new understanding until at some point we leave the circle with an understanding of the topic of the hermeneutic encounter. However, that understanding is accepted as temporal truth that is open to further questioning which may lead us back into the circle at another time.

> Analogously, we may ask whether or not we ever arrive at the point where we understand what really is . . . precisely because this dialogue is infinite,

> because this orientation to things, given in the pre-formed schemas of discourse, enters into our spontaneous process of coming to an understanding both with one another and with ourselves, there is opened to us the infinity of what we understand in general and what we can intellectually appropriate. (Gadamer, 1986, p. 493)

B. Working with Women in Research

Any question that involves women's experience and their perception of that experience necessarily involves women's participation in the search for an answer. This premise led to consideration of my views of women in general and women's participation as respondents or subjects in specific. Ultimately, this meant examining my personal values and beliefs in this regard. The research had to meet not only the ethical standards of human subjects' participation in psychological research, but my perspective on ethical standards regarding women in such research. Simply stated, this meant that the research concept and procedure had to be congruent with the values and beliefs I hold as a woman, a feminist, and a therapist. These values have been present throughout this study, from its inception to its conclusion. Just as the method of inquiry chosen for this study reflects my understanding of Gadamer's hermeneutics, the way in which this hermeneutical method was applied to working with the women in this research reflects my understanding of feminist approaches to research methodology and my view of feminism.

Feminist methodology is often referred to in the literature as though there is a consensus in the definition of that term (Bain, 1986; Cook, 1983; Deckard, 1979; Eichler, 1985; Lepine, 1985; Malmo, 1983; Roberts, 1981). Yet, like many researchers who identify themselves as feminists, I found myself "uneasy about the vagueness and ambiguity associated with the term" (Cook, 1983, pp. 127-128). This "uneasiness" led to a literature search for an understanding of the term, feminist methodology, as an idea and practice.

Standard dictionaries require that we look at the two words in this term separately. Similarly, dictionary definitions encourage us to look at each word's root and suffix in order to come to some understanding of a word's meaning. Using this as a

beginning produces some seemingly simple definitions. A feminist is one who adheres to or advocates the doctrine, system, or tenets of the corresponding noun, feminism. Methodology is the study of systems of procedure or action--methods. It would seem to follow that feminist methodology is the study of methods (primarily, research methods) by one who advocates feminism. While this may be true, it does not seem sufficient to understand how that feminist perceives feminism or how she studies research methods.

Feminism: A Personal View

Feminism is generally used in a social context with particular focus on the ideology of a society and its impact on the individuals and groups existing in that society. Specifically, feminism grew from a concern about consequences for women in a society which feminists deem to be sexist in ideology. Feminism provides "an alternative viewpoint" (Eichler, 1980, p. 9) to the prevailing ideology of western society sexism.[4] That alternative is a negative view of sexism and represents an opposition to the prevailing ideology. As such, it contends that the ideology of sexism has negative consequences for women.

Deckard (1979) proposes that the ideology of sexism developed and survived "to justify and maintain a particular status quo--in this case the dominance of the male over the female. A ruling group always requires an ideology to justify its position of power" (pp. 11-12). In this context, feminism critically questions and challenges women's position in this society. This is a challenging position in itself to take when one considers the following:

> The sexist ideology is well integrated and elaborate. Its major premise is that woman is inferior to man. It is sufficiently flexible (inconsistent) so that any behavior a woman exhibits can be interpreted to conform with the major premise. The ideology is so pervasive that, until recently, few people were aware of its existence. Its tenets were simply accepted as self-evident truths. (p. 11)

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[4]It may be important to note that Eichler (1980) refers to feminism as a viewpoint and not an ideology. That viewpoint may be considered women's view of sexism from the point of the oppressed.

Feminism proposes that the acceptance of the prevailing ideology's tenets as self-evident truths and the subsequent lack of awareness in regard to their pervasiveness and prevalence are the result of the socialization process and further illustrate the social context of feminism.

It seems reasonable to surmise that the prevailing ideology of western society is viewed positively by those who perpetuate its position whether or not they are aware of their advocate position. Any alternative or opposing viewpoint would have to take both a negative stance in its view of the prevailing ideology and in the way it is viewed by advocates of the status quo. Feminism's critical view and analysis of every aspect of society represents a potential threat to that status quo which is being protected, justified, and maintained by sexism. Such a large arena of investigation demands the largest part of feminism's attention. It encourages feminists to use most of their resources to expose the negative consequences of sexist ideology and diminishes the resources available to develop an ideology of its own. Further, it perpetuates a negative view of feminism by focusing primarily on what feminism is against rather than what it is for. Any non-sexist ideology that may come from feminism is held at a developmental stage until this focus begins to shift. Therefore, feminism cannot, as yet, be considered an ideology, but rather an opposition to a prevailing ideology and it is through this opposition that we come to some understanding of feminism and the feminist perspective in methodology.

It has been established that feminism brings a critical perspective to society as it exists (Eichler, 1985). This feminist perspective is succinctly presented in point form as follows:

1. that the formal institutions of society are male-dominated and male-oriented;
2. that women hold a secondary status in relation to men;
3. that the dominant ideology reflects and supports the perception of women as subordinate to and less valuable than men; and
4. that women have been discriminated against and oppressed on the basis of sex. (Malmo, 1983, p. 25)

Feminism objects to and opposes this status of women in society and seeks to change this position of women. Feminism holds that discrimination against, prejudice towards,

and oppression of any class of people, particularly on the basis of sex, is a destructive aspect of any society. Specifically, the feminist viewpoint implies that sexist ideology is responsible for a negative and destructive view of women and that that view, in turn, produces a negative and destructive consequence for society as a whole.

In addition to opposing the oppression of women, feminism advocates the personal as the political. In general, this proposes that women's personal experience is a valid way to examine the political. Stanley and Wise (1983) suggest that two feminist beliefs are embraced within the idea that the personal is political:

> The first of these concerned the essential validity of personal experience. Feminism insisted that personal experiences couldn't be invalidated or rejected, because if something was felt then it was felt, and if it was felt then it was absolutely real for the woman feeling and experiencing it. The second was the feminist insistence that the traditional distinction between "objective" and "subjective" was false. The traditional male emphasis has been on objectifying experiences and so "getting away from" the personal into some transcendental realm of "knowledge" and "truth." For feminists the key consequence of this is that it denies validity to women's understanding of women's experiences, because these are "merely" subjective, rooted in the particular. (p. 53)

Such a viewpoint advocates that women's understanding of women's experience is a valid way to understand the world. These experiences represent the way women see and understand the world and feminism contends that they have been ignored or rendered invalid by the dominant ideology.

Finally, feminism advocates removing barriers that hinder women from sharing their experiences and views of their lived-in-world. Consciousness Raising groups are one example of how women have shared their views with each other. However, this can be considered only a first step towards women sharing their reality in a larger sphere. Feminism advocates not only that women's reality be heard and accepted by society, but that the ideology of that society should change as a result. Above all things, feminism demands that women be heard.

To understand how a feminist approaches methodology requires that we understand her feminism. Experience has shown that while all feminists share some common themes in their feminism, we differ in "the exact meaning and implication of these for theory, for research, and for how we live our everyday lives" (Stanley & Wise, 1983, p. 51). Therefore, it seems appropriate at this point to state as clearly as possible how my feminism has implications for research methodology. First, methods were critically viewed with particular attention to sexist bias and influence. It was important that the method employed in this study be as free as possible of power differentials between researcher and respondents and that the women in the study were not treated as objects of study. Second, the methods were viewed for their potential to make the personal the political. That is to say, methods were evaluated on the basis of their ability to generate women's experience and their understanding of that experience as a valid information base rather than imposing a pre-conceived knowledge base. Finally, methods were studied for their ability to allow women to talk about their experience and be heard by themselves and others.

Feminist Methodology

While feminist methodology most often reflects the perspective of the individual feminist, it is also a complex concept that resists simple definition. In addition, feminist methodology is in a developmental stage (Cook, 1983) and, therefore, temporal in any definition at this time. The social context of feminism is reflected by feminist methodology being developed more in disciplines with a social context than in other disciplines (Cook, 1983; Eichler, 1985). Finally, socialization may have left its mark, no matter how subtle, even on feminists, so feminist methodology continues to explore the potential infiltration of sexist bias even in its own work. Because feminist methodology encompasses more than an individual feminist's perspective, one must consider it from a larger perspective.

Simply stated, methods are systems of procedure or action. Specifically, methods are systems employed in inquiry, such as research, and methodology is the study of these methods. Kaplan (1964) suggests that "the aim of methodology is to help us to <u>understand</u>, in the broadest possible terms, not the products of scientific inquiry

but the process itself" (p. 12). While it is tempting to describe the process of feminist research methods by comparing them to traditional methods, Cook (1983) contends that "such comparisons obscure the interplay between the epistemological ideas and the technical practice of feminist methodology by highlighting the differences in methodological techniques across (and even within) disciplines, and ignoring over-arching similarities in the methodological assumptions of feminist researchers" (p. 128). Throughout the literature, it is evident that feminist scholars and researchers are employing a variety of methods--quantitative and qualitative, traditional and non-traditional, experimental and descriptive. In practice, feminist methods of inquiry are similar to traditional methods, so comparisons seem an unproductive approach to understanding feminist methodology. Moreover, Cook (1983) observes that feminist methodology suffers in such comparisons "by appearing to be too amorphous and undefinable" (p. 128). It is not so much the methods employed by feminists that are of interest, but the way existing methods are studied and how they are utilized.

As stated earlier, the existing literature on feminist methodology draws heavily on research in sociology and other disciplines with strong social context components. The application and practice of feminist methods and scholarship in psychology has traditionally borrowed from these disciplines (Bain, 1986; Malmo, 1983). Historically, the academic perspective of feminist scholarship emerged from the women's liberation movement which "looked critically at scientific and other theories to examine to what degree they bolstered and maintained patriarchy while at the same time often claiming to be value-free and neutral" (Eichler, 1985, p. 619). Eichler (1985) identifies four stages in the historical development of feminist methodology: "(1) a focus on women; (2) a focus on sex roles (gender roles, gender relations); (3) the development of a feminist approach; and (4) a focus on epistemological concerns" (p. 620). Throughout this development, one theme has remained constant: a critical attitude towards sexism with a focus towards exposing and overcoming these biases (Eichler, 1985).

In addition, certain assumptions characterize a feminist approach. The first assumption is that there is an informational gap in existing research data due to inadequate representation and consideration of women's experience and perspective. Eichler (1985) suggests that "societies cannot be understood if we fail to understand the

female experience" (p. 622). Ballou and Gabalac (1985) contend that criteria and data for mental health reflect "the white, male, middle class experience" (p. 164). They recommend that "that must change to include both the experience of others and contradictions between them. Also, research and theory building must be expanded to include eclectic methodologies including those which listen directly to people's experiences" (p. 164). Cook (1983) identifies four major ideas involved in a feminist critique of research and theory that have implications for feminist methodology:

1. there is a lack of information about women's worlds;
2. there is bias because of the lack of women researchers;
3. there is a need to re-conceptualize phenomena to include women's experiences; and
4. the kinds of research questions that are asked have crucial implications both for the results and for practical action. (p. 145)

Thus, the first assumption in a feminist approach is that women's experience needs to be an integral part of reconsidering and reconceptualizing our knowledge base, particularly in the social sciences.

The second assumption of a feminist approach to research is that most societies "are characterized--whatever their differences--by being patriarchal. Patriarchy, in turn consists of and reinforces the social, cultural, economic, and sexual oppression of women and girls" (Eichler, 1985, p. 622). Inherent in this assumption is an understanding that oppression is undesirable and destructive for women and the society as a whole. Once again, this assumption also implies the need to reconceptualize the research and theories that perpetuate this oppression and justifies Eichler's (1985) statement that "feminist scholarship must work towards a new theory of knowledge, premised on the notion of equality of the sexes rather than inequality" (p. 622).

The third and final assumption of a feminist approach to research involves the notion that research can be objective to the point of being value-free. Eichler (1985) states that "all scholarship is by necessity value-oriented, whether this is admitted or not. Most non-feminist scholarship is sexist, insofar as it accepts the inferior social, economic, cultural, and sexual position of women as unproblematic and may even serve to actively maintain patriarchy" (p. 622). This observation is also evident in Cook's (1983)

observations about the need for women researchers to offset the existing bias in research and the crucial importance of the kinds of research questions that are asked. It also points to the importance of examining the value-orientation of any research or researcher so that it does not become hidden or unaccounted for in the research results. It would seem that stating one's self as a feminist researcher or as using a feminist approach in research indicates, to some degree, the value orientation that will be a part of the results. However, the definitional and meaning dilemma addressed earlier would indicate that each individual feminist scholar would have to make a statement of values, because, at this time, there does not appear to be a consensus among feminists regarding a definition of feminism and its concomitant values.

Specific details of how these values are translated into conceptual frameworks and procedures of data collection and analysis are scant in the literature. Eichler (1977) identifies three characteristics of feminist research: (1) women are regarded as subjects rather than objects; (2) rejects men as the norm to which women are compared; and (3) "it reconstructs reality by starting from a female perspective which may or may not need to be modified as men are taken into consideration" (p. 410). More specifically, Driscoll (1987) identified six characteristics of feminist research methodology: (1) the researcher should be in contact with the people she is studying; (2) there should be provision for feedback between the researcher and informants; (3) the researcher's own participation and experience should be a consciously used part of the research process; (4) both conceptualization and methods used for getting information should incorporate the interests and insights of the people being studied; (5) the social context and the intricate connections between the various aspects of life should be dealt with; and (6) a continual self-consciousness focused on the research process itself should be part of the work. Levine (1987) also stressed the importance of including parts of the researcher's experience of daily living that seem relevant to the topic and "the need for feminists to continue the so-called absolute practice of recounting personal experience, in everything we do, including feminist research" (personal communication, Feb. 10).

In summary, feminist methodology is the study of research methods from the perspective of feminist values as the researcher understands them. In practice, the research methods employed by feminists are varied in design, but generally reflect a

feminist perspective. In this study, the design of the research inquiry reflects my understanding of feminist values and seems consistent with the characteristics of feminist research set forth by Eichler (1977), Driscoll (1987), and Levine (1987).

C. Summary

Both Gadamer's (1986) dialectical hermeneutics and feminist's methodology contend that value-free, neutral knowledge is a myth perpetuated by positivist-based, empirical science. Similarly, it appears both propose that stating as clearly as possible our values and preconceptions can enhance the research process as long as the validity of these values and preconceptions is suspended in the process and left open to reconceptualization. Therefore, this study makes no claim to universally valid truth or value-free, neutral knowledge or understanding. Rather, it endeavors to make the researcher's values and preconceptions clear throughout.

The value of experience as a source of understanding and knowledge has been stressed by both Gadamer and feminist scholars. Feminists have advocated making the personal political, thus validating women's experience as knowledge of the world. They point to the information gap that exists between existing knowledge and women's experience and stress the importance of getting back to experience in order to close that gap. Gadamer has noted that experience "is the ultimate to which we come back" (p. 60). Therefore, this study takes the return to experience to be its mandate.

The characteristics of feminist research set forth by Eichler (1977), Driscoll (1987), and Levine (1987) do not seem to be compromised by employing dialectical hermeneutics as described by Gadamer (1986). The design of the method of inquiry employed in this study incorporates the characteristics of feminist research while simultaneously constructing the text that became the partner in the hermeneutical encounter. The specific procedures of the research process will be addressed in Chapter 4 and may be regarded as the result of reflections and ponderings of the literature which were my companions in the return voyage to the Land-of-Experience. It occurred to me that this voyage itself could be considered a potentially never ending circle of understanding and questioning that would bring one repeatedly from the Land-of-Experience to the Land-of-What-Is-Said and back again until one day we dock in

port and rest--temporarily and tentatively--with "what we understand in general and what we can intellectually appropriate" (Gadamer, 1986, p. 493) at that time and in that space.

IV. PROCEDURE

> Everything that is experienced is experienced by oneself, and it is part of its meaning that it belongs to the unity of this self and thus contains an inalienable and irreplaceable relation to the whole of this one life. Thus its being is not exhausted in what can be said of it and in what can be grasped as its meaning. The autobiographical or biographical reflection, in which its meaning is determined, remains fused with the whole movement of life and constantly, accompanies it. It is practically the mode of being of experience to be so determinative that one is never finished with it. [Gadamer, 1986, p. 60]

During the voyage back to the Land-of-Experience, the question reasserted itself: How do women who have experienced depression describe this experience and what meaning does that experience hold for them now that they are no longer depressed? My companions on the voyage, reflection and pondering, had made several conceptual suggestions as to how I could ask this question and find an answer. The experience of depression could be accessed by autobiographical reflection in which the experience is described and "in which its meaning is determined" (Gadamer, 1986, p. 60). The meaning of the experience could emerge through dialectical hermeneutic encounters with the text that this reflective account would produce: conversations in oral, audio-taped, and typed transcript form; entries in my personal journal; written feedback from the participants; and, non-verbal language observed during conversations. The characteristics of feminist research methodology (Eichler, 1977; Driscoll, 1987; Levine, 1987) must be applied to the research process so that the women in the study assume, as much as possible, an equal stance with the researcher and participate in modified collaboration. At first these concepts seemed disconnected, but eventually they became connected in the form of a paradigm that represented a plan of research based on these concepts. That plan became the map and itinerary used for my travels through the Land-of-Experience and is described and recounted below.

A. The Women

A pre-existing list of women who had volunteered for a study of depression that never materialized, an announcement at an assertiveness workshop for women, and word of mouth information about the study generated a pool of twenty volunteers for the present study. From this pool of volunteers, participants were chosen for this study according to the following criteria: (1) that they identify a period in their life as a

depression experience; (2) that they currently do not identify themselves as depressed or experiencing depression; (3) that they are not currently in therapy focused on their depression experience; and, (4) that they are willing to commit their time and energies to the research process as described by the researcher. The first ten women who met this criteria became participants in this study. Two women were chosen to participate in a pilot study and eight women were chosen to participate in the present study. Of these ten women, six came from the pre-existing list (two in the pilot; four in the present study), one from the announcement, and three from word of mouth information. Each woman identified herself as having experienced depression and as no longer depressed, although two were currently on medication that may have contributed to their no longer feeling depressed (one in the pilot; one in the present study).

Demographic information about the participants' current age, marital status, children, occupation, education, age during depression experience, and length of depression experience was collected during the process of the present study. The participants ranged in age from 26 to 63 years at the time of the study with a mean age of 40.1 years--two in their 20's, one in her 30's, four in their 40's, and one in her 60's. The marital status of the participants was by chance evenly divided between single, married, divorced, and widowed at the time of the study. During the depression experience, one reported being widowed, three married, three single, and one in transition between marriage and divorce. In regard to children, three reported having no children, two having one child, two having two children, and one having three children at the time of this study. Three participants reported having children under the age of 14 years at home during the time of the depression experience. Occupations reported by the participants included student, teacher, government employee, and counsellor. During the depression experience, five participants were students, one was in transition between work and retirement, one was a homemaker, and one was in her current occupation. The formal education level of the participants at the time of the study ranged from high school diploma to Ph.D.: one high school, one two-year college diploma, four bachelor degrees, one master's degree, and one Ph.D.

The age during and the length of the depression experience reported was difficult to calculate. Three women reported their suspicions that they may have been

depressed, on and off, during most of their adolescence and early adult years. Three women reported their depression experience as occurring in their mid-thirties, one at age 61, and one at age 23. Six of the participants had been labelled as depressed by members of the medical community and two were self-labelled. Two women had been hospitalized for depression, and the three women who had experienced depression starting in their adolescence had attempted suicide. The shortest period of depression reported was two years and the longest documented period of depression was fifteen years with a mean length of depression experience of six years. Five participants reported a length of their depression experience which ranged between two and five years, while the remaining three participants estimated the length of their overall depression experiences as ranging between ten and fifteen years.

All participants reported having received counselling during their depression experience. Two of these women reported only one or two visits to a counsellor, four reported receiving short-term counselling (less than one year), and two reported long-term counselling experiences (more than one year) during the depression years. Six participants reported medication being prescribed for their depression, five women took the medication, one refused. None of the participants was currently in counselling for depression, one was on mild doses of anti-depressants, and one had just come off anti-depressant medication.

Prior to embarking on the present study, consultations with my committee and the experience of the pilot study suggested that five or six participants would yield the possibility of integrating the information gleaned in conversations and connecting the themes that emerge during the hermeneutic experience. During the process of the first conversations, I became concerned with the possibility of attrition in participants, so the number of participants was expanded to eight.

It does not seem enough to leave the descriptions of these women who participated in this study at mere demographics and rationale for selecting the number of participants. These are women who were willing to open up their private lives and experiences to the researcher, to the study, and, through these pages, to the reader. Each expressed a desire to contribute her experience to further our understanding of depression in women. Each seemed to indicate that sharing her experience of

depression would add to its meaning if it helped others, particularly women who were depressed. For me, these were courageous women who were willing to expose themselves in order to help others. During the research process, I not only became fascinated with them and their stories of depression, but gained a deep respect for them individually and collectively.

B. The Process

Prior to commencing this study, the researcher had volunteered to be a participant in a study of depression and was one of the names on the pre-existing list mentioned above. As it turned out, I was the only participant ever interviewed for that study. During that interview experience, I reflected on my personal experience of depression and gained some insight into how it felt to be a participant in such a study. The audio-tape of that interview was given to me and became my partner in a hermeneutical encounter. This encounter with my own experience and my encounter with the literature became integrated into my perspective and preconceptions of depression in women that would be put at risk during the hermeneutic encounters with the experiences of the women participants in this study. My encounter with the literature has been discussed in Chapter 2 and my encounter with my own experience of depression was presented as an autobiographical reflection in Chapter 1.

The paradigm or plan of research employed in this study incorporated a modified collaboration between the researcher and participants through reflective accounts of the depression experience, dialogal interviews (hereafter referred to as conversations), and hermeneutic encounters with the transcripts of the conversations. Instruments used to generate material for this study included two conversations, one reflectionnaire, two typed texts that were transcriptions of the conversations, the researcher's personal journal, and audio-tapes of the conversations with each participant. The sequence of this process is presented in the form of a flow-chart in Appendix A. For this discussion, the research process has been divided into four phases that describe the sequence and content of that process.

Phase I.

Because the researcher's own participation and experience should be a consciously used part of the research process (Driscoll, 1987), I kept a personal journal (Progoff, 1975) to chart my external and internal experiences throughout the study. This began in August, 1986. This journal has many sections, each with a specific purpose, where entries are made. For the purpose of this study, only four sections need to be briefly described. The "Daily Log" section resembles a diary where minimal descriptions of external events and succinct reflections of internal processing are recorded daily. It was in this section that I recorded telephone contact and meetings with participants, activities related to the research process such as reading the texts, other significant events, and the internal processing and reflecting of the day. The "Period Log" section positions the writer in the present moment in her life by recording significant events, people, relationships, work, activities, and issues that have contributed to her being in that moment, that "Now." This became the reference point and framework for all the other sections of the journal and for my position as this study began.

The "Dialogue with Persons" section records significant people in the writer's life and establishes a format for internal dialogue between each person and the writer. It is in this section that each participant became a partner in a dialogue between myself and my perceptions of each of them. This became useful as a reflection on my sense of each participant as a person and not a research subject. The last section, "Dialogue with Works," was a dialogue between myself and this study. It charted the course of our relationship, our interaction and our purpose. This established that the researcher and the research were not separate, but integrated in a partnership which had its ups and downs and a commitment to see the relationship through.

So it was that Phase I of this study began. Before making telephone contact with possible participants, I found myself filled with both excitement and apprehension as indicated in the following journal entry:

> This is like standing back and looking at a roller coaster that I've built! I know every trestle, every turn, every rise and fall, every section of track--all the details of the design. Now I am about to make phone calls that will place cars upon the tracks, each with an occupant unknown to me at this time, but

> destined to become my partner in this experience, this personal and hermeneutic encounter. On paper it looked good. How will it be for each of us to experience it?

Each participant was first contacted by telephone at which time she was given a brief description of the study, and an appointment to meet for the first conversation was arranged. Each participant was given the choice of where and when that meeting would take place. Seven participants chose to meet at my office and one, at her office. All initial telephone contacts and first conversations occurred between the last week of August and October 24, 1986.

At each first conversation, the research process and the participant's role in that process were described in detail. After a relatively short discussion in which any questions were answered, a consent form (Appendix B) was distributed and signed. During the first conversation with each participant, I stated that I had had the experience of depression and that I had similarly given a reflective account of that experience in an audio-taped interview with another researcher. This seemed to establish some rapport between us and dispel some of their concerns, stated and unstated, about sharing their personal experience of depression.

Establishing a common ground through similar experiences may contribute to an equal partnership in the conversation, but it may also leave the partners with the impression that they understand depression and its language in the same way. Therefore, it seemed important to state that I would take a stance of not knowing throughout the conversation and would be asking questions that would help me to better understand their language and their experience.

At this point, I asked the participant to tell me what depression is and to tell me about her experience of depression in any way that she liked. During their reflective accounts, which naturally took the form of somewhat one-sided conversations, I asked questions of clarification and contributed bits of my own experience that seemed germaine and appropriate to the conversation. These interruptions to the natural flow of their narratives were kept to a minimum. It seemed necessary at times to ask questions or to make comments when a participant got stuck, lost the momentum of her reflective account, got lost in theoretical generalizations and away from her personal experience,

or needed my participation in the conversation in order to know that I was still with her. Every effort was made to avoid introducing my preconceptions into her experience and to use her language in my comments and questions. This conversation was designed to open her experience of depression as she lived it, to bring that past experience into the present so that we could each get to know it in a new way as it was being told and could encounter that experience once again in a hermeneutic experience with its text in Phase II.

It is difficult to fully explain what happens during this type of reflection. In the beginning, there seems to be a distance between the woman and her experience. Gradually as the narration gains its own momentum, the past seems to become alive in the room in the present. The experience is no longer "over there" as something to be observed and dsecribed. It is "here" and we are in it. This change can be noted in changes in affect and language. Tears, agitation, and anger were expressed as the experience came closer. Language moved from past-tense observation to present-tense and feeling. In many instances, the women reported remembering things they thought they had forgotten or had not thought were important at the time of the experience, but seemed important now. For each, the past seemed to present itself for her rediscovery in the present. An experience thought to be dead had come alive for her consideration and mine. For six of the participants, this transformation was noticeable during the conversation. For the other two, this change was reported to have occurred when they reflected on our first meeting and read the text of that conversation.

Based on my own experience as a reflective narrator and what I had observed occuring during the participants' reflective accounts, it seemed appropriate to spend some time talking about our present at the end of each first conversation in order to re-orient to our current state of being in the world. Part of this conversation focused on the reflectionnaire (Appendix C) that they were given to take with them. The reflectionnaire was designed to stimulate reflection on the first conversation experience by each participant and by the researcher. Each participant was encouraged to keep notes on these reflections and bring the results to our second conversation. The first conversations generally ended by removing the microphones, turning off the tape recorder and engaging in casual conversation about our present.

The first conversations were audio-taped using two lapel microphones--one for the participant, one for the researcher--so that both voices could be clearly heard on the tape. The conversations lasted between one hour and one hour fifteen minutes which represented the period starting after the consent form was signed and ending after the reflectionnaires were distributed and described. These tapes were personally duplicated with the researcher mantaining possession of the original and sending the copy to the transcriber in Los Angeles, California via air express. Participants were identified on these tapes by a code letter, C through K. The transcriber did not know any of the participants except the researcher and had never been to Edmonton. This mode of transcribing the tapes was chosen to protect the anonymity of the participants. One tape, participant H, was transcribed by the researcher. This was done as a comparison to determine whether self-transcription would enhance the hermeneutic encounter with that text. For me, self-transcription of the tape was a time-consuming process that tended to keep my focus on small sections of conversation as they were transcribed. There was less time and personal energy to do the journal work with H's first conversation when compared to other first converstions. Moreover, there was a tendency to view H's first conversation as parts that create the whole, while other conversations were reflected upon as wholes before addressing the details or parts of the typed transcripts. While this may reflect my individual style of transcribing and reflecting, it seemed that descriptions and interpretations were thicker or richer for me when someone else did the transcribing. Therefore, all subsequent tapes were transcribed in Los Angeles.

Before and after each telephone contact and conversation, entries were made in my personal journal in the appropriate sections. A review of these entries indicates that each participant with her related experience remained an individual for the researcher. Although there were some instances where something in one participant's account would be reminiscent of another participant's account, there appeared to be minimal integration of the accounts prior to reading the typed texts of the transcribed tapes. The most notable difference during the course of these first conversations was the increased ease with which the conversations flowed and kept on track. Conversations with the first participants tended to be longer and contained periods where the

conversationalists got off the topic more often than in conversations with later participants. However, this did not appear to notably alter the information generated by these conversations. It seemed rather to indicate the researcher's growing ease with this type of conversation and her increased ability to guide that conversation without interfering with its content.

All first conversations with all of the participants were completed before any typed texts from the transcribed tapes were read or any feedback from the participants was obtained. This was done so that each participant and each conversation would be treated as equally as possible. In leaving each participant at the end of our first conversation, it seemed important to acknowledge her uniqueness and courage in sharing her experiences with me and to recognize her contribution to this study. All participants were told that it may be some time before we met again and that they should feel free to contact me before that time if they felt the need. None of the participants contacted me prior to my contacting them at the beginning of Phase II.

Phase II.

Phase II began in November, 1986 when all of the transcribed texts had been received and duplicated. At this point, I read all of the texts and listened to all of the tapes several times. This hermeneutic encounter proceeded according to the following pattern for each participant: (1) listening to the tape and making notes, (2) reading the text and making marginal notes, and (3) reading the text while listening to the tape and making further marginal notes. These steps were followed in one block of time for each participant's conversation. The notes took the form of highlighting certain words or phrases that attracted my attention, questions of clarification and meaning penciled in the margins, and thematic words that seemed to represent the essence of a section of text. The order in which transcribed texts were read was different from the order in which the conversations took place. Sequential layering may have occurred in the course of the conversations and that might have been reinforced by following the same order in interpretation. In this first hermeneutical encounter with the texts, each participant was encountered separately, so that our "horizons" could meet and I could further my understanding of her and her unique experience. During this time, I often referred to

journal entries about her and our conversation and I took time to reflect on my sense of this person and her experience. This direction was taken to fuse our horizons in such a way that I could become immersed in her and our conversation, come to a knowing of each individual and her experience, and interpret the text from that position.

Once this was done, I called an imaginary meeting where all nine of us would engage in an imagined conversation. What did we have to say collectively? I tried to hear their questions, their salient points, the said and unsaid of their texts, their likenesses and their differences. I heard myself adding my own experience to the conversation and raising questions that had emerged during my hermeneutic encounters with the texts and from this meeting.

This imaginary meeting began during a leisurely walk, continued through meditative periods for several days, and came to written language through journal entries such as the following:

> Daily Log: November 8, 1986. Today I decided to take a break from work--take a walk, get out of the apartment! To my surprise, the women decided to do the same thing. One by one they joined me and engaged in conversation with me and with each other. [At one point I laughed when I saw all nine of us jump to the side as a bicycle passed us and realized the cyclist only saw me!] Each of us had things to say, questions to ask--yet, each was listening to and considering each other's experience. Several words came up over and over again--fear, helplessness, self value and definition, control over one's life. We continued to dialogue throughout the day (even during grocery shopping). Tonight I want to continue this dialogue in the appropriate section of this journal. [Too bad these meetings have to be imaginary--just imagine what we could accomplish if we all really met! No, some (maybe most) would be too embarrassed or private to share if they actually met.]
>
> Dialogue with Persons: November 8, 1986.
>
> M: First of all, thanks for joining me on the walk today. I enjoyed your company and it helped clarify my thinking and feeling about our conversations. Can we continue?
>
> E: Could we talk about change? That seemed to be a big factor in my depression--lots of changes.

C: Maybe I didn't notice the significance of change in my experience, but you seemed to notice--change in marital status, change of living style, change of cultures. Lots of changes and each seemed to include some loss.

D: Change and loss seem to fit for me, too. Change of working to retired meant a change from my identification as a working woman. Becoming a widow changed my status in a couple oriented society. Both marriage and work were part of how I identified myself and they were lost in the change.

M: Change and loss were certainly a part of my experience--Change in moving to California, living on my own, economic level of living lowered drastically, marital upset and separation, change in work--lots of changes and loss.

G: That doesn't fit for me. Change might have been welcomed. For me, being helpless in a depressive family has more meaning.

H: Me too.

F: I agree.

M: OK. Let's talk about that.

This dialogue went on in this entry and subsequent entries between November 8 and 12, 1986. It is important to stress that these are not the actual words of the participants, but my imagined conversations or dialogues with them. This five-day imaginary meeting helped me integrate my understanding of each participant's experience and my interpretation of each transcribed tape at that point in time. The results of this imaginary meeting were the agenda that I was to take to our second conversation.

Each participant was once again contacted by telephone to set a time and place for the delivery of her copy of the transcribed text and for our second meeting. Each participant was given one week or longer between the delivery of her text and the second conversation. Each copy of text was hand-delivered and accompanied by a cover letter (Appendix D) that gave some direction for how to read the text. During a pilot study, participants often concentrated on grammatical and spelling editing at the expense of reading the transcription for meaning, understanding, and experiencing. Therefore, it seemed important to direct the participants' reading of their transcriptions to assure as much as possible that, as partners in the second conversation, we would not be talking at cross purposes (see Methodology, p. 17). This cover letter asked

participants to read the transcript for understanding, meaning, and further experience, as well as to reflect on and react to their reading. The process recommended in the cover letter was presented as the approach I used in reading the transcripts; however, the participants were also directed to read the transcript in any way that felt comfortable for them. In summary, the participants in the pilot study had indicated to me that some direction for how to read the transcript would be helpful and the cover letter presented in Appendix D was developed to that end.

The pilot study had established that participants are somewhat shocked when they first read their own conversation and accounts. In every case, a participant's first comments are about her use of language:

> The frustration of, you know, it's a script, that word for word, as opposed to an edited one and that is frustrating. So many ums and ahs.
>
> I'll never say "you know" again!
>
> There were so many uncompleted sentences and disjointed conversation--so many pauses, ums, and "you knows." I always thought I was a better conversationalist than that.

Therefore, the first direction in the cover letter was to read straight through the text the first time to re-establish the flow of the conversation and avoid making grammatical and editing corrections that would interrupt that flow. In subsequent readings they were directed to take a more leisurely approach to their reading, making comments and markings in the text whenever they felt like it and taking time to pause and reflect whenever it felt right to do so. Immediately after each reading of the text, they were asked to write their feelings, reactions, reflections, and questions on a comment sheet that was included in the cover letter. Finally, they were asked to bring their copy of the transcribed text, their reflectionnaire and any written reflections they may have made regarding the depression experience and the first conversation experience to our second meeting.

Second conversations with the participants occurred between November 13, 1986 and January 29, 1987. Once again each participant was given the choice of where and when that meeting would take place. Second conversations took place in the same settings as first conversations with one exception: one woman whose first conversation

had been at my office chose to meet at her apartment for our second conversation. All these conversations were audio-taped, duplicated, and transcribed in the same manner as described in Phase I with the exception of participant H's tape which was transcribed in Los Angeles rather than by me as noted above. These second conversations lasted between one hour and one and one-half hours.

The content of second conversations was determined by the agenda each of us brought to this second meeting. Each participant brought individual questions, clarifications, and additions that emerged from her reflection on the first conversation and her reading of her transcript, so that part of the content of the second conversation varied individually. The agenda I brought to this conversation resulted from integrating the information and connecting the themes that emerged during my hermeneutic encounter with all of the participants and all of the transcribed texts. This agenda remained constant throughout second conversations and included the following: (1) demographic information, (2) reactions to the first conversation, (3) reactions to reading their transcript, (4) reactions to the research process up to that time, (5) questions that asked for their assumptions and pre-conceptions regarding depression, (6) reactions to words that emerged as thematic in the transcripts, and (7) questions they thought I should have asked.

Demographic information about the participants has been presented above. Responses to items 5, 6, and 7 above are discussed in the following chapter, because they deal more with the description and meaning of depression for these women than with the research procedure.

Reactions to the research procedure were indicated in responses to the first conversation, to the reading of the transcript, and to the research process in general. Reactions to the first conversation came primarily from the questions on their reflectionnaires. Each of the questions and the participants' responses are presented to indicate how the research procedure impacted the participants and the degree of effectiveness this process offers in generating information about the experience of depression:

Responses to the first question--what was it like for you to speak with me about your experiences?--focused on elements of trust, pain, healing, accuracy, or clarity in

their conversations, and positive feelings about themselves. Trust seemed to be established through sympathetic, non-judgmental listening and through my identification as a woman who had been depressed:

> Very comfortable. Felt empathy and trust right away. Felt therapeutic and healing, largely from the quality of sympathetic listening--sense that you could easily take whatever I might say with interest and without judgement. It was reassuring to know that you had also been depressed at one time. It made me feel more at ease and less alone.

The comments about the painfulness of recalling the depression experience seem to indicate the degree to which the past experience came alive in the first conversation.

> Painful to remember, re-feel, and speak of past "down" experiences.
>
> My sense is that I was struggling to get a hold of feelings, because I was divorced from them, very distant from them. Definitely a difficult but helpful experience.
>
> Speaking to you about my experiences brought back a great many memories that were rather painful for me, but I think it was also a healing process.

Yet, each woman who mentioned the painfulness of talking about her depression experience also mentioned that the conversation had been helpful in seeing her situation in a new way, usually a way that enhanced her sense of self:

> It was interesting to see returning aroused some anxiety, but mainly gratitude and joy for being well and strong, renewed interest in working on the crap still left.
>
> It was very positive for me, realizing that I have come a long way in the last four years.
>
> It just made me look back on my life and think, "Well, look what you've done with your life. And look where you came from." It just sort of bothers me that I have to hide those kinds of things from people that I know. Because, in a way, I'm almost proud of the things that I've done. I guess maybe because it's a part of what I am!

Although some women voiced concern that they had "babbled on" or hadn't been clear, concise, and chronological in their accounts, this seemed to be more the result of

talking about themselves more than they were used to and in an uninterrupted way. Their transcripts were no more unclear, inconcise, or scattered than the transcripts of the women who did not voice this concern. Overall, the responses to what it was like to speak to me about their experiences were positive.

Responses to the question of what impact the first conversation had for each participant stressed the importance of talking to someone about her experiences, of re-examining and clarifying the experience, of remembering what it was all about, and of "a-ha" experiences:

> The conversation brought back memories of the depression itself. I think I had not realized that it was still quite painful to me to talk about it, but I was at least able to talk to someone about my experiences and that in itself is a step in the right direction. It is always positive to re-examine yourself and to take time now and then to look back from where you've come from. I think it helps you figure out where you're going.
>
> I can almost see a pattern that developed, so that was very helpful for me. Part of it was closure in being able to really crystallize in my mind what was going on at the time.
>
> Recalling these experiences or verbalizing much of the experience for the first time was sort of startling--an "a-ha" experience. I felt a lot of that was useful, helpful to me personally, sort of clarifying some stuff. A lot of the time I hadn't experienced what was happening to me. I hadn't been angry at the time about it. Later in the evening anger came closer to the surface.

Most of the women expressed increased insight into their depression experience as the most notable impact of the first conversation. One woman reported that she left the first conversation feeling that she had not been able to relate "how bad it really was." It is interesting to note that this same woman also reported that her depression had seemed "a huge thing," "unbelievable" prior to the conversation, but "Now it doesn't feel as big as it did before."

In response to the question of whether or not they would recommend participation in this kind of study to a friend, the overall answer was "yes":

> I would recommend to anyone who has been depressed to participate in such

a conversation, because I think it helps heal the psychological wounds.

Once again, most women reiterated their desire to contribute to our knowledge of women's psychological and social dilemmas and "to contribute what I can to solving women's mental health traps." One woman stated that she would have been somewhat reserved in recommending participation to a friend based on the first conversation alone, but after reading her transcript she would recommend participation without hesitation. Her life's experience with psychiatrists and institutions had left her "bitter" and "skeptical," but after reading her transcript, she decided to make an appointment with a woman psychologist to "work out some of the feelings of resentment and anger."

The meaning attributed to the first conversation was primarily one of validating their experience, validating themselves, and giving themselves a sense of contributing:

> It validates my experience!
>
> There was meaning because I was able for once to talk it out with somebody. I've done a lot of changing and a lot of growing.
>
> The conversation was meaningful in the sense that when I was asked, my thoughts were: "If it will benefit someone else, it will all have been worthwhile." It made me take stock of my situation in terms of what I had achieved since.

It is important to note that meaning is inherent in their responses to other questions previously mentioned: being able to talk about it to someone for the first time, gaining new insights and perspectives on the experience, and gaining a sense of accomplishment or pride in how far they have come.

Most of the participants had no response to the final question on the reflectionnaire: Have you any other comments or suggestions regarding the conversation in light of your experience? One woman suggested that the "interview was too short to start getting into depth." However, that was prior to reading the transcript and the second conversation which did go into more depth. Another woman simply asked a question I couldn't answer: "Do you think what you are doing will make people more aware of the hell depressed people go through?"

Responses to reading the transcript of the first conversation were overall quite positive. While every participant reported initial concern over the script style of the

transcript, these concerns had to do with seeing her conversational style in print for the first time. Comments in this regard were about their use of language, repetitions and irrelevancies, incomplete sentences, grammar, things being out of sequence or unclear. However, in no case did these concerns keep them from getting the substance of what they had said during the conversation.

Three of the women read their transcript once, one read hers twice, and four read theirs three or more times. Four of the women made extensive marginal notes in the transcript and on the comment sheets. These were the women who had read their transcripts three or more times. Two women made minimal notes in the margins and on the comment sheets. The remaining two women, who had read their transcript only once, made no notes while reading their transcripts. During the course of the second conversation, the three women who read their trasncripts once, including the two who made no notes, stated in various ways that they had some concern that reading the transcript would resurrect their depression. To my knowledge this has not happened. However, it may be worth noting that the two who made no notes are still chronologically close to their depression experience and the other woman still carried the belief that depression was like a seed in her that could grow again. However, all three women reported some positive gain from reading the transcript:

> Depression is not such a threat as it was before reading.
>
> I think it helped to re-examine myself--where I came from.
>
> I realized that even though it [depression] wasn't the most positive experience in my life, it led to something more positive, which is something I wouldn't have done before reading.

The most often cited positive outcomes from reading the transcript were that reading it helped clarify things for them, gave them more objective views of their depression experiences, and gave them new perspectives on those experiences. Five of the women reported that reading their transcript had helped bring closure to that experience. Other positive comments included realizing growth through and since the experience, an enhanced sense of self, less guilt about the experience and things leading to their depression, enhanced ability to recall the details of the experience, and an "a-ha" experience. While reading their transcripts, some of the women reported being

surprised that they had been so open in the conversation and indicated that it was helpful to be able to talk about their experience.

Negative reactions to reading the transcript were minimal. One woman stated that when she came to a section of the transcript that elicited negative feelings, she could identify that content as something she had "not finished with yet." One woman who procrastinated reading the transcript stated that it was more from a fear of "not doing it right," than from fear of the content or process. Several women stated that reading the transcript recalled the feelings of that period in their life, but they did not categorize that as a negative aspect of the process.

Participant "H" seemed to have the most negative reaction to reading her transcript. She stated that she avoided reading her transcript because she anticipated reliving the feelings of the depression, so she rationalized not reading as a matter of not having time. During the second conversation, she seemed to contradict herself:

> When I came to the interview, I thought, "I'll just go in and tell my little thing here."
>
> Like, I was a third person recalling someone else's experience.
>
> Totally removed from the feeling part of it.
>
> I anticipated reliving the feelings and it didn't happen!

My reading of her transcript also left me with the feeling that she had told a story as though it were someone else's experience--entertaining, interesting, but with very little feeling. Yet, she was disappointed that the feelings weren't there:

> It didn't seem to come across as bad as it was.

During the second conversation, I asked her to describe the feelings, how bad it really was, and got this response:

> I don't think I could describe it.

There seemed to be a conflict between wanting to express the feelings, how intense the depression was for her, and staying protected from feeling those things again. She described this dilemma as either being so finished with the experience that she couldn't access it or as being so unfinished with it that recalling the feelings could send her into depression again. It seemed in the best interest of everyone concerned to avoid trying to help her come to any resolution of this conflict. It seemed appropriate to respect her

ability to make her own decisions and come to her own conclusions. In spite of her negative stance, she stated that reading the transcript had been helpful in re-examining herself, seeing where she came from, and had changed the way she interacts with her family.

Reactions to the research process up to this point were positive. Most of the women found the process interesting and a learning experience. Several commented on the fact that it was a lot more work than they initially thought, but they didn't seem to mind that work. Two women stated that the research process had stimulated them to begin or renew keeping a personal journal. One woman reported that the process helped her find a language for describing her depression. Several women stated appreciation for someone listening to and regarding them as experts of their depression, and that the research process so far had been better than therapy:

> Personally, it's been better than therapy. I think because of the focus, because of simply wanting descriptions of the experience and because you are sitting there simply as a totally involved listener. And the energy that's going back and forth. I certainly feel total trust in the integrity of how it's being handled. And then I also really believe that this kind of thing is really important, that we need new ways of looking at depression. Women's experience.

As stated above, the remainder of the second conversation was directed towards their assumptions and pre-conceptions regarding depression, their reactions to thematic words, questions they felt should have been asked, and anything they had brought to this conversation. Most of what they brought pertained to the depression experience and will be dealt with in the following chapter. Any questions they had regarding the research procedure have been discussed above. However, several women wanted to know, once again, how the material was going to be used and expressed a desire for it to eventually become a book that women could read. They wanted their experience to benefit women, to make a contribution. After explaining the dissertation process, I acknowledged their contribution and shared their concern that women should be able to benefit from their experience, as well as their work in this study.

This second conversation ended with an explanation of what my tasks would be in the next phase of the research procedure and that it might be some time before I contacted them again. They all expressed a desire to read the dissertation and I reminded them that they had editing privileges and would be among the first to read it. Once again, each woman was given a telephone number where they could reach me if they had any questions. To this date, no one has called.

All second conversations were completed before any typed texts from the transcribed tapes of these conversations were read. Similar to Phase I, personal journal entries were made for each conversation. These entries indicate that each participant now appeared before a backdrop of the integrated experiences of all the participants, as well as their own experience. While the participants remained individuals for me, they were becoming a group rich in their experiences and knowledge of those experiences. Comments in the journal often noted similarities and differences.

Other entries indicated the increasing awareness that the work, this study, was taking on a life of its own. "Dialogues with Works" and "Daily Log" sections of the journal show an increased immersion in the study and the life-experiences of these women. The participants seemed to have become my daily companions, my co-workers, and the work we were doing seemed to pre-occupy my thoughts and feelings. Our "horizons" had met and we were becoming immersed in the work of understanding our experiences and depression.

Phase III.

During this phase of the research process, the transcripts were read in two ways. First, all texts of second conversations were read in the same way described in Phase II. Second, each participant's combined texts, tapes, reflections, and comments were integrated and read. The first way of reading the texts of the second conversations alone gave me a comprehensive view of content of these conversations. It integrated their responses to the agenda I brought to the second conversation. Some of this integration was presented in the discussion of Phase II. It also allowed me to see individual differences and similarities in what they brought as an agenda for the second conversation. The second way of reading the transcripts allowed me to note any

changes, additions, or deletions, and general clarification of each individual's account of her depression experience. This allowed me to gain a richer sense of each participant's experience. It was during this reading that themes began to emerge for each individual as well as for all of us combined. Our voices, all speaking at once about our depression experience, gave birth to a new, singular voice that spoke for all of us.

There seemed to be a musical quality to the emergence of themes. In musical counterpoint a single voice can present a series of notes that become a theme. Often that same voice will develop that theme through elaboration and variation and will go on to present new series of notes or new themes. Other musical voices will likewise present those same themes in a different timbre or range--sometimes backwards or upside-down, but the same themes nonetheless. Each voice has its own character and uniqueness. Following each voice throughout the musical composition, one can identify its themes, their development and variations, and note how the voices and their musical material are alike and different; yet, this identification or analysis does not give us the full, rich sense of the musical composition. It is in the layering and interweaving of the many voices that the music comes alive. Now we can hear its harmony with its dissonances, resolutions, and consonances. Only when these voices are heard together in point and counterpoint do we gain a sense of what the composition is about. Similarly, each participant became a voice in the counterpoint of this study. The materials for each participant revealed her themes and their elaboration, variation, and development. As in music, the composition of this study would not exist without these single voices with individual themes. Yet, it was in the layering and interweaving of the participants' voices, as perceived by this listener's ears and experience, that this study gained a life of its own, a voice of its own that could not exist without this joining of voices and experience.

Immersion in the combined conversations, tapes, texts, reflections, comments, and journal entries for each participant created a separate space where each individual's voice and "horizon" met and merged with mine into a new voice, a voice that captured the essence of the related experience and spoke in a language of themes. As Gadamer (1986) had stated, this immersion was me applying myself to the text, so that I became part of the meaning I apprehended. It was my fore-understanding which was questioned

to determine "the true prejudices, by which we understand, from the false ones by which we misunderstand" (Gadamer, 1986, p. 266).

Each immersion into the conversations and materials for each participant was an hermeneutic encounter which involved the hermeneutic process of interpretation. The themes that emerged were not predicted, but were the result of the openness with which I immersed myself, my experience of depression, my being a woman in the world, and my fore-understanding into the life-world each participant had shared with me. Therefore, the themes and meaning set forth in this study must necessarily be considered the truth that emerged for me from the inexhaustible well of the texts and was inextricably tied to the point in time in which the participant's "horizon" and mine met. It is a temporal truth which represents where I left the hermeneutic circle and must remain open to further questioning, interpretation, and understanding. There is the sense that I will re-enter the circle in future hermeneutic encounters with the text and find new truths and understanding throughout the coming years of my being-in-the-world.

On a pragmatic level, the conversations for each participant were divided according to topic areas. Marginal comments in the texts tended to be summary statements about the substance of each section of text. These summary statements were clustered into essential themes for each participant's depression experience as it had been related in our conversations. This process is illustrated in Appendix E.

Summary statements and themes for each participant were then compared to each other to note similarities and differences. Through this process, themes that emerged in the individual texts were clustered into major headings or themes that represent the combined experience of the participants. These themes represent the description of the experience of depression as I heard the voice that spoke for all of us, the voice that captured the essence of our related experience. In some cases, this was the voice of consensus, of a common experience of being-in-the-world. In others, it was the voice of uniqueness, of an individual, distinct state of being-in-the-world. These themes are presented in Chapter V and include an acknowledgement of where the voice spoke for all of us, some of us, or one of us.

During the conversations that were a part of this study, it became apparent that these women held certain assumptions about depression as a result of their experience.

Therefore, the following questions were asked to each participant during our second conversation:

How would you recognize someone who is depressed?

How would you interact with someone who is depressed?

How could friends, family, or professionals help someone who's depressed?

What are your views of medication for depression?

What would you like to tell women who are depressed?

What do you think causes depression?

What helped you come out of depression?

Do you think women can prevent or avoid depression? How?

These questions emerged from my hermeneutic experience with the participants' first conversations. These questions and their answers are not considered themes or descriptions of depression, but rather some of the meaning that the depression experience holds for the participants. Their answers were considered, compared, and integrated into a discussion of these questions which is also presented in Chapter V. Once again, commonalities and differences were noted and discussed in terms of their distinct and individual experience of depression.

In addition, the overall meaning that each participant ascribed to her depression experience was interwoven throughout her conversations and written comments. Being depressed or having the depression experience held some meaning in the context of her total life's experiences. This meaning came both from what was said and what was not said. It came from the spoken word with all of its nuances and affect as well as from the written word as it appeared in transcripts and comments. It came from the visual cues of gesture and affect as they were observed during our conversations. It necessarily bears the imprint of my being-in-the-world at the time of our encounter and represents my interpretation of all that was seen and heard in words and silences. The discussion of the meaning of the depression experience in the lives of these women is presented in Chapter V.

In addition to interpreting the texts and materials generated in this study, Phase III included a re-visitation to the literature on depression in women. It seemed important to

reconsider this literature in light of the changes that inevitably occurred in my understanding and preconceptions of depression as a result of this study. This second literature review is integrated into the discussions presented in Chapter VI.

The final task in Phase III of this research procedure was the production of a first draft of this dissertation. The research design employed in this study and my personal beliefs and values demanded that the women in the study be given a final hearing as well as some editing privileges. These women had provided feedback or modified collaboration throughout the research process and it seemed important to continue that in its culmination. Therefore, Phase III ended with what must be considered a first draft of this dissertation.

Phase IV.

During the final phase of this study, a copy of the first draft of this dissertation will be hand delivered to each woman who participated in this study. At that time, she will simply be asked to read it and make any comments or corrections that she wishes. After a reasonable amount of time, each woman will be contacted and asked for her reactions and feedback. It is anticipated that some women will be able to give their feedback by telephone, while others may wish to meet again. Their corrections and editing will be considered and discussed during those contacts and, if at all possible, incorporated into the final draft of this dissertation. The description of those contacts and the women's feedback will be presented in an epilogue, Chapter VII.

V. DESCRIBING DEPRESSION

Chapter V presents a description of depression that emerged from conversations with women who identify a period in their lives as depression. It describes an experience of being-in-the-world that has been given the label, "depression." In order to present a description that reflects the richness of these conversations, the lived experience of these women will be presented in three sections; [1] themes, [2] metaphors, and [3] "Tell women who are depressed . . ."

A. Themes

Ten themes emerged from the reflective accounts of these women's depression experience and their interpretation of that experience. Each theme represents one aspect of each woman's individual experience, as well as their collective experience. Therefore, commonalities and idiosyncrasies within each theme will be considered. The order in which the themes are presented does not reflect any common hierarchy of importance. Each of us would rank the importance of these themes differently according to our individual experience. Finally, although this chapter presents a composite portrait of women's experience of depression, it recognizes the individuality of the women who shared their experience and their unique contribution to the following description. It recognizes Gadamer's (1986) perspective on experience:

> Everything that is experienced is experienced by oneself, and it is part of its meaning that it belongs to the unity of this self and thus contains an inalienable and irreplaceable relation to the whole of this one life. (p. 60)

During our conversations, the women in this study described their depression in terms of what was going on inside them during that experience and what was going on outside them during that experience. Their depression is reflected in both their view of things inside and their view of things outside. Both views are necessary to complete the picture of depression described by these women. Therefore, the following descriptions will be presented in two sections: inside themes and outside themes.

Inside Themes

The following themes describe depression as it was experienced inside these women. During our conversations, these women often spoke of being in a space or world inside themselves and expressed this world most often in terms of feelings and thoughts. This is a world that cannot be seen from outside the experience. In the themes below, these women allow us to step into their inner space and see depression as they saw it--from inside their experience.

The "Self"

The conversations with the women in this study abound with references to "self": how that "self" is defined, how it is valued or devalued, and how that "self" is criticized or blamed. The "self" emerges as a central focus during that experience of being-in-the-world.

Self-Definition. Many women described depression as a time when they didn't know who they were, as a time when they knew who they were not, or as a time when they were searching for a definition of "self." For all of the women, knowing who they were held great importance. For many, their depression was a time of movement from a "self" defined by others to a "self" defined by self:

> E: Both my depressions were periods of moving from a self that was defined by other people to a self that was defined by me or is becoming defined by me. . . . It's really important to me, that self-definition, at this point, and who I am in relation to things.
>
> J: For me it was developing a self-definition and developing who I was. . . . Because when I think of that now, I think I was always talking about independence, but probably more of what I was developing was my own self-definition.

For F, defining herself was more than a choice between being defined by others or by self. She described it as a fear that there was no "self":

> It feels like the fear that I don't know who I am. So that it's almost like no matter what I do or say or think, it's not acceptable. Like it just goes beyond sort of having a choice of saying, "I could be this way or this way and they all want me to be this way, so I'd better do that," but to not even knowing

what I want or who I am.

For F, the search for a definition of self carried the fear that it would end with her being "invisible" or "just disappearing." Part of the unsaid, but heard in these women's converstions was the shock of coming to a knowing that they didn't know who they were and the associated fear that they would never find out.

Often the search for self-definition began with a perception of not fitting any definition. This was often presented as knowing who she was not, but not knowing who she was. H describes her perception of not fitting in the following:

> Finding Mainstream, U.S.A. I mean, it never existed for me, so I was constantly trying to find it. I was tired of being a square peg in a round hole. I just didn't fit anywhere and I had no place to fit.

Perceiving that she was different from others was part of the experience described by each woman in this study. Even those who didn't know who they were, had some concept of who they were not. Without exception, being different was described as a painful experience.

Self-Esteem. The perception of being different led many of these women to make judgments concerning their value which were often manifested as negative self-views:

> G: Actually, I think that was the biggest one--fear of not being normal, not being able to experience life normally. . . . I always felt there was something wrong with me.

Being different than what they perceived others to be or what they perceived others expected them to be left these women with a negative mode of defining themselves. In various ways, each woman seemed to come to the conclusion that being different was not acceptable and, therefore, meant that something was wrong with her.

Being depressed seemed to add to this negative self-view. At the time of the experience, being depressed was unacceptable; therefore, they were unacceptable if they were depressed. Being accepted was fundamentally important to these women. It meant they had some value to others, even if they didn't know what that was. Being depressed jeopardized their being accepted (by themselves as well as others) and led them to further question their self-value or self-esteem:

D: I felt that I was looked upon as a third-class citizen, because of the depression.

H: Nothing that I seemed to do made sense anymore. It was like my brain had gone numb and that I was a really terrible person. My self-esteem was in a negative number, if that's possible.

In order to have a sense of who you are not, you must have a sense of who others are, who others expect you to be, or who you expect you to be. Knowing who you are not means you have compared yourself to someone or something. In most cases, these women felt they suffered in that comparison:

K: Trying to do things and always falling short and always expecting so much. All of the things I saw could be done if I was only a better speaker or smarter or better with people or--you know. Why couldn't I do what was expected?

J: I always felt that I wasn't quite good enough. I was supposed to be something that was just this much better.

In addition to the comparisons described above, some women compared their perceptions of themselves with the perceptions they felt others had of them. Discrepancies between these perceptions led these women to conclude that they were frauds, they weren't what they appeared to be. They seemed to reason that if the image they projected was valued and they were not who they projected, they must be of less value than that image. This reasoning appeared in professional, social, and relational contexts. No matter what kind of comparison or in what context the comparison appeared, most women left the comparison with a lowered sense of self-worth or self-esteem. Through comparisons of some kind, all of the women in this study concluded that they were different. With two exceptions, these women viewed being different negatively and they lowered or lost their sense of self-esteem.

For C, there was a sense of "self" that was self-defined. Her depression did not seem to involve a search for a self-definition. Rather, she felt satisfied with her definition and valued it. Her self-definition, often stated in broad terms, involved being in community, relating to people and belonging. Her depression involved feeling that her self-definition and self-esteem were in jeopardy. A geographical and cultural change

placed C in the position of establishing connections with new people in order to maintain some of her self-definition and confirm her self-worth. It was within the context of her experience that she would be accepted and valued. When this expectation wasn't met, she felt hurt and devalued:

> I didn't fit . . . the way I thought I would. There were days when I felt I was invisible. . . . I wasn't recognized as being present or as having a worthwhile input.
>
> I think a lot of my feeling down was the fact that I was expecting other people to confirm me and was waiting and they weren't.

C compared herself to the people in her new environment, found she was different, but tended to take a negative view of them rather than herself. Nevertheless, C describes this experience as "a major blow to my self-esteem." She describes the lack of confirmation of her value as a more important factor than self-definition in her depression experience.

The second exception was E who states that she "doesn't quite understand the concept of self-esteem":

> I really believe that we all have our strengths and we all have our weaknessess, that's integral. I have lots of self confidence in a basic sort of way now and during most of my life.

For E, self-esteem was not an issue in her depression experience. She describes her depression as a time of coming to terms with her feelings, gaining a new understanding of herself through those feelings, and coming to a self-definition through that understanding. Judging or evaluating her own or others' value does not appear to be part of her experience during her depression. In addition, E describes her depression as a process of accepting and understanding herself, particularly her feelings as part of that "self," rather than looking for acceptance and understanding from others.

Self-Blame. In addition to self-definition and self-esteem, self-blame or guilt emerged as a factor in these women's experience of depression. Every woman in this study had something to say about self-blame, self-criticism, or guilt as a factor in her depression. Most of the women blamed themselves for being depressed and carried a sense of shame and guilt for feeling depressed during that experience. Once again, this

was reflected in their sense of self-worth. Depressed people were seen as less worthy than non-depressed people (See D's reference to "third-class citizen" above). In addition, many of these women expressed feeling guilty for how their behavior or depression was affecting others:

> C: I think the major guilt that I would feel would be if I felt that I was being too rigid and punitive towards my son. There were times there that I felt guilty about that.
>
> G: I can remember being in the hospital and feeling guilty about what I was putting my parents through, but I think I was so depressed that I just didn't even care. After a while, I was sort of beyond the point of feeling guilty about what I was doing.
>
> J: Guilt on how my behavior was affecting other people. What it was doing to my family.

The guilt or self-blame described in these women's accounts of their depression experiences was associated with not feeling happy, not being normal, not being a good person, being dependent, being a burden, failing in marriage, a loved one's suicide, abortion, needing time for one's self, and for having unjustifiable or unattended feelings. References to guilt and self-blame are found in all the descriptions of depression presented by these women in our conversations.

Guilt and self-blame were additional burdens to an already diminished sense of self-worth and often led to suicide ideation and attempts. Three of the eight women came tragically close to succeeding in their attempted suicide. When there seemed to be no way to define themselves that was acceptable to themselves or others, these women wanted to end their experience of being-in-the-world. It may be important to note that the three women who attempted suicide described themselves as depressed most of their lives. It may be that this accumulated experience of depression was a major factor in their perception that there was no way out of depression other than suicide.

Overview of Self. Many of the women in this study described coming to a point in their life where they didn't know who they were or they were not, who others thought they were or they were not, who they thought they were, or some combination of these perceptions. Their depression experience was a period of defining or

redefining themselves. In addition, there was a questioning or loss of their sense of self-value, often referred to as "low self-esteem." Blaming that self--regardless of its definition or value or, perhaps, because of it--became part of their depression. As will be seen in the discussion of other themes below, their depression was an experience of feeling unacceptable to themselves or others or both.

During the depression, these women describe a perception of their world and experiences as confirming the unacceptability of that "self." In retrospect, some of the women continue to see the world and their experiences before and during their depression in the same way. Others can see some affirming and positive aspects of their experiences that were not perceived at that time.

Fear

All of the conversations with the women in this study included the theme of fear. Depression was a fearful time for all these women. At times, fear generalized to everything and anything. Fear became the intense light that blinded these women from seeing anything clearly, including the source of the fear. Other times, fear was more focused and specific. At times, the fear was intense to the point of overwhelming the depressed woman. Other times, it became a dull ache--ever present, but controlled by attention or inattention. Fear is a thread that weaves throughout the experience of depression described by these women--sometimes seen as fear itself, other times seen as part of another theme. Even when it isn't seen, the presence of fear is felt as these women speak of their depression experience.

Generalized Fear. Four women spoke of generalized fear. They described being fearful about almost everything and couldn't identify the source of their fear at the time. For them, fear was a pervasive, persistent companion in their depression:

> E: Irrational fear was one of the feeling components of depression. There was no cause for it. It was an inappropriate reaction to people, objects, events.
>
> G: When I was depressed, I did have a lot of fear of just everything. I mean, there was a lot of fear. I think I had enough control over myself that I wasn't fearful for other people. Mostly for myself.
>
> F: Fear would be fairly big, because you're afraid to react in any other way

. . ., the fear is keeping you doing it that way.

H: It's an overwhelming feeling. It catches your breath and squeezes you. It makes you look behind you all the time. It makes you think really funny thoughts that people are talking about you. I mean, all of a sudden there's all this paranoia where none existed before. . . . No matter how much you don't want these things to be happening, they still do.

While not all of the women spoke of generalized fear, they all identified three or more specific fears that were an important part of their depression experience. Sometimes these fears were associated with other themes and these fears will be presented in the discussion of those themes. Other times these fears were associated with parts of their total life's experience: being accepted/rejected, being overwhelmed by the depression, being different/not normal, hurting others, being dependent, the future, and making decisions. For each of these fears there was a background of experience that led these women to be afraid, i.e., there was an identifiable basis for their fears. During depression, these fears often became exaggerated or the women lost sight of the reason for their fear or both.

Being Accepted/Rejected. Being accepted held importance for all of these women--especially acceptance of self. For C, belonging and being accepted had been part of her life's experience and became part of her expectations. When she encountered a situation that projected the threat of rejection or non-acceptance, she became frightened and withdrew into what eventually became her depression:

Fear was certainly a pretty important part--fear of rejection and fear of being misinterpreted and misunderstood and fear of being undervalued, I think, was certainly a major part of that experience. It's a pretty frightening thing to think that if you expose your core to somebody that they will not value it and that's sufficient to make sure that you don't expose that core.

C spoke of still feeling that her fear of rejection was a realistic fear in that situation. For her, the fear of rejection led to a reaction behavior that, in turn, led to depression.

For some of these women, being accepted had been a life-long goal--one which they didn't feel they had attained. H described it above as searching for a place to fit. Having never found that place, H began to fear that she never would find acceptance.

Describing herself as the "weird, black sheep" of the family, H spoke of her family experience in terms of not being acceptable to them. For H, experience had led her to believe she wasn't acceptable to others or herself and to the fear that it would never be different.

Similarly, F describes a life of searching for acceptance. She tried to do and be all the things she had learned were acceptable. Her fear of rejection was presented as a fear that she was not what she appeared to be and that, if people knew who she really was, she would be rejected. Although not currently depressed, F still avoids talking about her life for fear that she will be rejected:

> I've also felt that by talking about it, people will not like me.

Six women spoke of the feelings associated with depression as unacceptable. The "dark side" of feelings which predominated in the depression was presented as unacceptable to the women and others during that experience. Nothing had prepared them to expect these feelings as part of their life's experience, especially when these feelings persisted with increasing intensity throughout their depression. They all referred to these feelings as negative and unacceptable. In many ways, these women became their feelings: they were unacceptable, because their feelings were unacceptable:

> D: I didn't want my friends to see me the way I was. I couldn't conceive of them putting up with such negativeness.

F couldn't justify her feelings and couldn't accept those feelings:

> I'd been searching a long time to try to figure out what was wrong. . . . We've been told it long enough: "I'm happy because I'm married." I used to think that. I used to believe it. It was a real shock when I realized I wasn't happy. . . . We're not happy, yet, we're told that this is happiness. How come that keeps happening? What the hell is this world telling us?

In E's adolescence, the feelings associated with depression had not been acknowledged. Her fear of these feelings stemmed from not having a reference point from which to understand what she was feeling. In the following, E describes her perception that her feelings were not healthy or normal, her frustration with others' denial of her feelings, and the importance of accepting these feelings as part of life:

> Nobody would accept that I really felt something that couldn't possibly be

> okay and healthy; therefore, not knowing if there was a time frame or if there was hope or help. . . . Reading Crime and Punishment . . . was maybe the first thing I had read or been exposed to that was an acknowledgment of the darker side and somehow it all let go with that. . . . Being able to delve into the darker side of ourselves. It is real! All these people who were denying this darker side of experience, maybe they're wrong. Once I knew it was okay, I didn't need to have it anymore.

Each woman described carrying the belief that the feelings they were feeling during the depression experience were to be avoided, rejected, or unacknowledged. Therefore, if you had these feelings, something was wrong with you and you were to be avoided, rejected, and unacknowledged:

> H: Nobody likes you to be sick that way and they certainly don't give you the right to be sick that way. So it's something that's even worse, because it's not an acceptable illness. So often I think that they push you through it rather than getting you through it. . . . People don't want to be around you, because you're not much fun. You're like a leper. If you don't cheer-up in a certain amount of time, well, people give up on you. So that's like having a terminal illness.

For all of the women, regardless of the focus of the acceptance or rejection issue, fear of rejection proceeded to withdrawing and not talking to anyone about their feelings or their depression. It was interesting that their descriptions of recovery from the depression were a reverse of this process. As they began to talk, they exhibited less withdrawal and began to accept themselves and find acceptance.

Being Overwhelmed by Depression. A fear of being overwhelmed by the depression emerged in every woman's description of that experience. This fear was often referred to as anxiety. Fear seems to have been present in every experience of depression, but anxiety seemed to indicate a fear of fear. As fear became persistent and pervasive in their experience, these women expressed anxiety that the fear would take control of their lives. This fear of being overwhelmed is illustrated by H's description of struggling to exercise some control over her basic processes after losing control at work:

> I would just sit there and stare at my work. I didn't know what to do. I couldn't do anything. . . . "Breathe. Concentrate on breathing." Because that was the only thing I could do and I knew if I could control my breathing then I wouldn't cry. . . . And I was out of control. Like, she tried to grab me and I just physically threw her off me and I said, "Get the hell away from me!" I just flipped out. Once I was out of there, I just thought, "Okay. That's fine. Go home. Just function. Walk. Get in the car. Drive. Park the car. Get out. Check the mail." Very, very mechanical.

Each woman described trying to regain some control over the depression. C sought professional help when she recognized how her behavior was affecting her son. D's fear reached its peak when medication exacerbated her loss of control and she dropped to her knees in desperate pleas for help from God. E's anxiety over having uncontrollable feelings led her to face her feelings through journal writing in order to gain some balance in control through understanding. F, G, and H tried to regain control by attempting suicide. K tried to regain control through understanding by attending workshops and seeking counselling. In addition, some of the women relied on medication as a way of avoiding being overwhelmed.

D, F, G, and H still carry some residual of this fear of being overwhelmed by depression. They express it as concern about depression returning, about their vulnerability to depression. H spoke of depression as an illness she will never get over and will always be susceptible to:

> I think what I believe or maybe I've been taught to believe is depression is like an illness. I don't know if you're totally ever cured, because I think that you've been knocked down a few times and it's like a spot that's burned away. So you'll never ever really get better. I guess I feel like a part of me has been injured and I guess I'll always limp rather than run. Although sometimes I do run, it's really easy for me to stop and say, "OH! It hurts. I'd better limp," 'cause it's like a crutch that I use. . . . I'm not sure if I'm confident enough to say, "The illness is gone. I'm cured."

D also views depression as an illness. During her depression experience, she carried the fear of being institutionalized, because she compared her depression to the mental

illness she had observed in her brother and husband who had been institutionalized. Now, she continues to use anti-depressants from time to time to prevent the return of depression:

> Well, I think one big fear right now is the fear of a depression happening again.

F describes her fear of depression as waking up with anxiety, with a sense of being paralyzed. G describes depression as a "life sentence" and continues to carry the fear of its return. G was institutionalized several times and carries a medical view of depression. This view, shared by D and H, seems to perpetuate their fear that they are vulnerable to depression. It was interesting to note that while all of the women in this study voiced some concern about depression returning, the fear of this return was most notable in those women who view depression as an illness.

Fear of Being Different/Not Normal. For many of these women, being different was equated with not being normal. Concern about not being normal became a fear associated with their depression experience. As noted above, E's fear that her feelings were not normal led to her experience of depression during adolescence. Once she found that her feelings were okay, a normal part of life's experience, she could accept and recover from her depression. While all of the women spoke in some way of feeling different, the fear of not being normal was most notable in the other three women who had experienced childhood or adolescent depression. These women differed from E in that they had encountered the medical system during their depression and had identified their families as dysfunctional in some way.

F had grown up in an alcoholic family with a grandmother who was identified as crazy included in that family. She had carefully observed and followed all the prescriptions she perceived as indications of normalcy: social involvement, friends, marriage, children, home, and lifestyle. She held the belief that these were the things that normal people do and that make normal people happy. When she had all these things and found that she wasn't happy, she felt different and not normal. In addition, F developed and presented an image of herself that she came to believe was different from who she really was. Together, her observation that she wasn't happy living a normal life and that she was different from the image she projected convinced F that

she wasn't normal, i.e., this confirmed her fear that she wasn't normal.

As presented above, G carried the fear of "not being normal, not being able to experience life normally," and this exacerbated her already diminished self-esteem. G had grown up in a military family that moved a great deal and that had an alcoholic father. Her observations of her family and other families had given her some sense of being different from normal families. Being the new kid in school and different from other kids was a consequence of the many geographical moves she experienced as a child. She became an observer who felt different from others. When she was institutionalized by her mother at age 13, G knew she wasn't normal, because she was in a place for people who weren't normal. Further institutionalizations and life's experiences continued to confirm that she was not normal and now her fear is that she may have passed that on genetically to her children.

H described her father as abusive and her mother inattentive. She was labelled the "weird, black sheep" in her family as well. H really wanted to be normal and was frustrated by not knowing how:

> I wanted to be normal like you wouldn't believe! I mean. "What can I do to be normal?"

In her description cited above, H spoke of her search for a place to fit that would give her a sense of being normal, part of "Mainstream, U.S.A." Her depression was, in part, a confirmation that was not normal.

All three of these women, F, G, and H, had strong motivations to be normal. Their depression experience confirmed their fears in this regard: being depressed is not normal, their life's experiences were not normal, and, therefore, they were not normal. It was interesting that not one of these women in our first conversation made any connection between their families and their fear of not being normal. At the time of their depression, they blamed themselves.

Fear of Hurting Others. Some women expressed concern about hurting others during their depression. Sometimes this was expressed as a fear that their behavior during the depression experience had impact on the lives of others. Other times, it was expressed as a fear that depression has a genetic basis and that their children had inherited a vulnerability to depression.

D withdrew and avoided her friends when she feared she was hurting them by her behavior. She also withdrew from her son when he criticized her for being depressed and unpleasant to be around. C observed the impact of her depression on her son. Her fear that she was hurting her son led her to seek help for her depression.

D still carries the fear that her son has inherited a vulnerability to mental illness, although that fear is more associated with her husband's and brother's illness than with her depression. G's fear of a genetic-link in depression is expressed in the following:

> The last psychiatrist that I saw said some people have chemical imbalances and so they're going to be depressed. I often wonder about that, because out of the five kids, I'm the only one who has B positive blood and my mother has B positive blood. I have one son that has B positive blood and I sort of thought, "God! Is he going to be the depressed kid in our family?"

H and J expressed some concern about the impact of their depression on their parents and families, but their concern did not seem to be a fear that contributed to their depression or a theme that represented it. To some degree, the same may be said of G. Even though this fear was not a major concern in most of these women's experiences, it did emerge as a part of the theme of fear and was congruent with the general concern for others exhibited by these women.

Fear of Being Dependent. Most conversations with the women in this study included some direct or indirect reference to issues of independency and dependency: C's dependency on others to affirm her self-definition and self-esteem, D's need to maintain her self-definition as a capable, independent woman, F's forced dependency on her husband, G's struggle with dependency on drugs and alcohol as a means of escape, and K's dependency on relationships that weren't working out. [E was the only woman who did not appear to have the issue of independence / dependence in her depression experience.] However, the fear associated with this issue was most notable in the experiences of the two youngest women in this study. For H, it was a fear that the person she was dependent on would not be there for her. For J, there was both a fear of being independent and of being dependent and this seemed to be a central issue in her depression experience.

Throughout H's conversations, there were situations described where she was dependent on others for acceptance and love. Her frustration in achieving this acceptance and love appears to have led to anger at the individuals upon which she was dependent, as well as anger at and fear of her dependency. This anger and fear led to her avoiding her family, which persists to the present. Her dependency on her physician for attention and caring led to outbursts of verbal anger during their sessions. Perhaps the best example of H's fear and anger about being dependent is seen in her description of her relationship with a counsellor:

> For about the first three-quarters of a year, I became very dependent on him. It was sickening. If he went on holidays, I would just think, "What would happen to me?" I was going to die, because he wouldn't be there for me. It felt so dependent. I had never really been that dependent on anybody. What a waste of my time, their time, I mean, I hated it!

H's fear of dependency appears to be a part of her life's experience as well as her depression experience. She felt dependent on others, disappointed by others, hate for her dependency, and, therefore, a fear of being dependent.

J describes a fear of dependency associated with a physical disability, being a patient, that was part of her life's experience. She described a period in her life where she struggled with accepting and challenging her abilities, while accepting and challenging her disability. She described a certain comfort with her reliance or dependency on friends and family and a discomfort with the losses that independence implied. Yet, her motivation for proving her ability to be independent prevailed. The cost was a period of doubt and depression.

One aspect of J's fear of dependency came from her observations that she was losing friends from "burn-out":

> I was very good at having friends and being around a lot of people, but not keeping really close friends for a long time. I was pretty needy and pretty dependent on those people and so I'd wear a person out and then have to find somebody else. I'd wear them out and find somebody else. It really surfaced in the time when I was 21 or 22. I went through a summer where I was again battling with the thought of independence.

The battle with the thought of independence was a period of ambivalence about independence and dependence. J recognized that gain of one was not without loss of another, and there was fear associated with either choice: independence or dependence. During our conversations, she spoke of her sense that no one could or would understand her ambivalence. In addition, this was a struggle or process she felt she had to do alone in order to own it. The result was isolation and depression.

In each woman's conversation, there was a sense of comfort and discomfort with independence as well as dependence. Moreover, there was a sense of dichotomy that led to ambivalence, rather than balance. The fear of dependency seemed to have a concomitant fear of independency. The depression experience seemed to include the question, "How can one be independent and dependent at the same time?"

Fear of the Future. Fear, regardless of its focus, in the present seemed to lead to a fear of the future. If this is where I am, how can the future be different? This was notable in the theme of helplessness where the women spoke of seeing "no way out" of their depression. Their view of the future became contingent on their view of the present. When one's view of the present is negative, one of pain and being overwhelmed, there is a projection of the present into the future. The fear that the present will continue without change becomes a fear of the future:

> E: I felt that I was being very clairvoyant and that all my fears were realistic. . . . Just lots of anxiety that the worst things that could happen would.

This fear of the future also seemed to be associated with the theme of control, predictability. Predictions based on their present seemed rather dim and fearful. As a friend of mine once said, "It's hard to see heaven when you're sitting in hell." These women seemed to be sitting in hell and their view of the future was tinged by that viewpoint. Their fear of the future was a fear that the future would be a continuation of the present. In addition, there was nothing in the present that gave them hope that the future would be different. Their view and fear of the future was a mere reflection of their view and fear of the present.

Fear of Making Decisions. Many of the fears discussed above contributed to a fear of making decisions. Decisions were seen in the light of acceptance and rejection,

controlling or being overwhelmed by depression, being different or normal, hurting others or hurting self, being independent or dependent, and of being in the past, present, or future. Throughout the conversations with the women in this study, there seemed to be a fear of making decisions based on the past or present that would impact the future. Perhaps, making decisions in the present was seen in the light of their decisions in the past and those decisions were seen as leading, in part or whole, to the depression experience of the present. The question arose in the said and unsaid of every conversation, "Are we capable of making decisions, having good judgment, based on past decisions that have led us to this place of despair and pain?" Regardless of the situation each woman found herself in at the time of her depression, there was a unilateral questioning of her ability to make "good" decisions or judgments and a concomitant fear of making decisions:

> J: I was battling with . . . how I could be myself and make my own decisions and be comfortable with making my own decisions . . . the fear of not having good judgment in what I'm going to do next.

Questioning their ability to have good judgment in making decisions seemed to arise when they blamed themselves for their depression. The unspoken question, "How can I trust myself to make 'good' decisions when I feel the way I do and when my poor judgment in making decisions in the past contributed to my feeling depressed?", appeared to lead to a conflict associated with sensing that they were in a situation that required making decisions and choices, wanting to make their own decisions, and a lack of confidence in themselves to make decisions that would have positive consequences for their lives. In many instances, these women described a sense of being forced into making decisions and not feeling capable to make decisions. Because of this fear of making decisions, they became self-critical, indecisive, and more depressed.

Overview of Fear. The depression experience described by these women was an experience of fear. For some women, fear generalized to everything in their experience at that time. For others, fear was more specifically associated with an aspect of their total life's experience, as well as their depression experience. In our conversations, they spoke of their fear of being rejected or not being accepted, their fear of being overwhelmed by and not surviving the depression, their fear of being different or not

normal, their fear of hurting others by their depression, their fear of being dependent or independent or both, their fear of the future, and their fear of making decisions. While all of these women spoke of fear as part of their depression experience, no woman included all of these fears in her description of her individual experience of depression.

The descriptions of depression experience included varying degrees and intensity of fear. All of the women spoke of a fear of the depression in some way and for many this fear reached an intensity that seemed overwhelming or paralyzing. Other fears emerged in various combinations from the individual descriptions of the depression description. No description was without reference to fear as an important factor in the depression experience.

Isolation

During the conversations with the women in this study, isolation emerged as a theme in their depression experience. Isolation was described as a feeling of being alone in the world and in the experience. They spoke of psychological, sensory, emotional and, at times, physical isolation. Isolated by being inside and not talking. Isolation was not always a painful experience. For some, it created a smaller world, one which they could handle. For others, it was a safe place where they could rest from the demands of others. However, there was always a tinge of sadness in their descriptions of being inside, not talking and feeling alone--isolation.

Being Inside. Isolation was described as a space, "where I was," during the depression experience. Sometimes the women would gesture or point towards their chest when they spoke of that space. This space did not seem to be outside of them, but rather inside them. J's reference to "out there" indicated that her "own little world" was inside. Their focus had turned inward to a space they only knew, a space they didn't talk about and nobody else could enter.

Isolation for these women during their depression experience was a space inside. F described it as "just my space and where I was." H uses similar words, but adds "I didn't feel okay with where I was." Most of the women did not describe their being inside as a comfortable space. J describes it as her "own little world" that was both fearful and calming:

I would isolate myself in my own little world to try and get control of my

> own little world before I tried to be part of whatever else was going on out there. . . . Isolation at times became very fearful when thoughts or feelings went out of control or would be blown out of proportion in my mind. I felt like I couldn't control them. And then isolation would be very calming for me if I felt like everything out there was out of control.

There was also a sense that she, like most of the women, took responsibility for being isolated inside. However, taking responsibility for and liking the space were two different things. No one described their being inside during the depression experience as a space they would like to re-enter.

Part of the pain of their self-imposed isolation was that being inside cut them off from people and things.

> E: The feeling of sensory and emotional isolation, of not being able to make contact with people or even with objects in a way that felt as though you were alive. It was sort of the muffledness of emotions causing that isolation rather than necessarily feeling that the world was isolating me. I could kind of tell, even then, the cause of a lot of the isolation was in here [gestures to her chest]. There were very strong feelings of it.

For H, part of being inside was being out of touch with anybody or anything, including her feelings:

> You couldn't feel anything. Rather than feeling sad or feeling mad or feeling really anything. Depression was a void of feelings. . . . It was easier not to feel. It was easier just to be a zombie.

For me, what emerged during our conversations was a sense that being inside was necessary to do whatever had to be done in the depression experience, but being inside meant loss of contact with people and things. Most of the women described this loss as painful and sad. Moreover, the longer they stayed inside, the longer this loss continued and many women expressed the fear that they didn't know how to reach out from that space or let anyone reach in. C described it as not knowing how she got in it, not knowing if she could handle it, and not knowing how to get out of it. To some extent, these women chose to isolate themselves and then became afraid that they couldn't come out of that isolation.

Whatever was going on during the depression experience was going on inside each woman. As the women spoke of isolation, I got the sense that being inside, being involved in that individual internal space and process was not only difficult to talk about then, but difficult to talk about in the present as well.

Not Talking. Part of the isolation described by these women was a lack of communication between two worlds: the one inside and the one outside the individual woman. This was seen in their many references to not talking. Every woman spoke of not being able to talk about things, feelings, and thoughts that were meaningful to their depression experience.

C chose not to talk because of her fear of being misunderstood or misinterpreted. The unsaid in many of the other women's conversations was to some extent a similar fear of being misunderstood that led to not talking, although they indicated that that fear included an element of not understanding themselves and a fear of non-acceptance.

D didn't talk because she was ashamed of her husband's illness and suicide, being battered, and her depression. The shame referred to by other women, as well as D, seemed to arise from a non-acceptance of their feelings or of depression in themselves which was projected on to others. However, it was within many of these women's experiences to have witnessed the non-acceptance of depression and the feelings associated with depression, i.e., there was some experiential basis for their assumption that depression was not acceptable. Experiencing something that was not acceptable led to shame which, in turn, led to not talking about it.

F, C, and E experienced geographical moves that cut them off from people they might have talked to. The friends that they might have trusted to hear what they had to say without judgment were not available to talk to. For G, frequent geographical moves as a child and adolescent prohibited her developing a network of friends to talk to. G identified most of her life as depression and not talking and expresses her feeling of isolation below:

> When you're depressed, there's just nobody you can talk to, nobody can understand your depression. Just so alone. That's part of the heaviness and the big lump in the pit of our stomach. That's a real thing.

H also identified most of her life as depression and not talking and describes her not talking in the following:

> The more I got into it [depression], the worse it got, because I had no outlet. . . . I could not bring myself to talk.

K spoke of circumstances blocking her being able to talk about her feelings and her depression. As a working woman, the telephone represented her link to those she could talk to. Censure of using the telephone at work for personal calls severely limited her ability to talk about her personal issues and depression. Because many of her personal issues were related to her work situation, she was further isolated by not being able to talk to anyone at work about her problems. In addition, her husband didn't understand her work problems when she tried to talk to him, so she felt limited by not being able to talk about those problems at home as well. In many ways, K described not talking as a cause, as well as a feature, of her depression.

J described not talking because of her fear of losing friends. She had experienced the loss of many friends through what she described as "burn-out." She carried the perception that friends could not withstand the content or expanse of her need to talk, so she stopped talking.

Several women stated that our conversations were the first time they had talked about their depression outside of counselling. Some of the women referred to having grown up with the understanding that there were some things one should not share through talking and these things were most often the things involved in their depression. The combination of socialization, circumstances, and life's experience contributed in some way to every woman's description of isolation by not talking.

Feeling Alone. During the depression experience, each of these women described a heightened awareness of being alone in this world. Isolation was often described in terms of this awareness:

> G: You're alone. There's nobody and that's a real scary feeling. You are completely alone in this world. As a matter of fact, I remember thinking at different times in my life that very thought, that I am completely alone in this world and it was a terrifying thought.

There was a certain circularity to these women's experience of being alone. Regardless

of where they started in the circle, it included a recognition of being alone in this world, a sense of being in a space inside themselves that they alone knew and they alone could visit, and not being able to talk to anyone but themselves in that space.

What emerged from their conversations was not simply a sense of being alone in this world, but a sense of being limited to being alone by and during their depression. There did not seem to be a balance between their sense of being alone and their sense of being connected in their life's experiences. Part of this limitation or imbalance seemed to be associated with the internal processes that kept them inside themselves during the depression. Part seemed to be associated with their not talking to anyone outside of themselves about this process. Being alone became frightening when there was no sense or experience of being together at that time.

Overview of Isolation. Isolation in these women's experience of depression emerges as a feeling, rather than an observable physical phenomenon. Isolation is a feeling of being cut-off from others. This feeling of isolation is described as a recognition of being alone in this world, a heightened sense of being alone, a sense of having to focus on a space inside as part of the experience, a loss of experiencing connectedness and togetherness in this world, and an inability to connect with others through talking about the depression and its issues.

In some ways, isolation allowed these women to attend to themselves, to focus on their concerns at that time. Metaphorically, they were stepping into a space inside themselves that was demanding their attention. The difficulty and pain of being in that space emerged when the door to that space was closed by not talking to and not connecting with others at that time. Feeling limited and trapped in that space heightened their awareness of being alone and exacerbated the pain of being alone and their fear that there was no way out. Any comfort associated with being in that space inside, being isolated, was lost when they felt the door close.

Social Withdrawal

Whereas isolation was described as a feeling of being alone, social withdrawal was described as a behavior of being alone. Social withdrawal was an observable behavior--a behavior that sometimes occurred by choice and other times, by circumstance. In our conversations, social withdrawal emerged more as a symptom of

depression than a description of depression. As a symptom behavior, social withdrawal indicated a response to factors descriptive of the depression experience: fatigue, hiding / shame, uncontrollable emotions, circumstance, and getting sicker / getting well.

Fatigue. In our conversations, these women described depression as taking a lot of their energy, so that they didn't feel they had energy for anything else. They were fatigued by their depression. Social interaction required an energy many of these women didn't feel they had, so they withdrew. G's words were:

> Yeah, I guess that's social withdrawal all right! I just couldn't face anybody. Too depressed. Couldn't make the effort.

During the depression experience, attending to one's self was an effort and J expressed doubt that she had the energy for that, let alone for attending to others:

> I couldn't deal with anybody else besides me and I couldn't even deal with me at that point.

D describes her fatigue similarly:

> I didn't have any social functions whatsoever. Absolutely nothing. For a year and a half or so, I went down the drain and didn't seem to be able to have the energy to pick myself up again.

Energy was described as an exhaustible commodity and these women described depression as a time of little energy left in their supply.

Hiding / Shame. In many ways, social withdrawal was described as hiding from others, often out of shame. A lot of the conversations about social withdrawal were interwoven in the theme of "self." Many of the women spoke of being ashamed of that 'self' and, therefore, hiding that "self" through social withdrawal.

C spoke of hiding herself from social contact because of her perception that she would be misunderstood and not accepted by the people in her social situation at that time. D spoke of her son's criticism as the cause of her withdrawing from him and her shame regarding her "self" and experiences as causing her to withdraw from others. G described hiding her "self" from others most of her life. Her social withdrawal was described as hiding her emotions, particularly crying, from others. H spoke of depression as something every woman has to hide. She also observed that functioning during depression was a way to hide depression from herself as well as others. H

described holding on to her depression by hiding it from others:

> The withdrawing part was so that I could at least have my depression.

J's social withdrawal was her response to feeling ashamed:

> I withdrew socially, because I felt ashamed of myself for the way I was feeling and looking and being.

Hiding, in some form and for some reason, was a part of every woman's conversation about the experience of depression. Social withdrawal was their way of hiding something associated with their depression from others in most cases and their way of hiding their depression from others in every case. Depression is something that these women perceive as socially unacceptable; therefore, the depressed woman hides her depression through social withdrawal, often in shame.

Uncontrollable Emotions. While all of the women spoke of feeling out of control of their feelings and behavior in some way, two women spoke of uncontrollable feelings and emotional behavior as part of their social withdrawal. G describes social withdrawal during her adolescent depression as a response to her inability to control her crying:

> When I was really depressed, I would go to dances and sit in the bathroom all night. Like, I did that a lot. Too afraid of what they'd think of me. Afraid I would start crying. I did that, too. Afraid that I would make a mistake, like crying, because I used to cry at the drop of a hat.

In her description of losing emotional control presented above as her fear of being overwhelmed by depression, H withdrew from work when her crying and anger became uncontrollable.

For both G and H, depression had reached an intense level and the control they had been exercising on their emotions was weakening. Their concern, and sometimes their experience, that their emotions were no longer controllable led them to withdraw socially rather than let others see those emotions and the behavior associated with them.

Circumstance. Six of the women in this study described their social withdrawal as circumstantial to some degree. For these women, social contact was limited or lost due to circumstances in their lives outside of their depression.

Four women spoke of geographical moves that separated them from social contact. C was faced with a new social context as a result of her move to Canada. Her

initial attempts at social involvement in this new context were threatening to her self-esteem, so she stopped trying to be social. For C, it was more avoiding building social involvement than withdrawing, although she still refers to it as social withdrawal.

E describes her circumstances as an absence of social context rather than social withdrawal:

> We were in two different towns during the time of my depression. Both new. Therefore, the social context wasn't there. I couldn't tell if I was withdrawing or not, because if I'd had a social context that I was used to and then had done something different in relation to it, I would have known, been able to understand that better.

Like C, E's limited social interaction was more the result of not building a social context than withdrawing from it.

G described a life of frequent geographical moves with little opportunity to build a social context. Her social context was constantly changing and G was adjusting to that change rather than withdrawing. G described her social situation when she said, "I didn't really have a lot of friends anyway."

For F, the circumstances of her limited social interaction were a geographical move, her husband's censure of her friends, and her roles as wife and mother:

> I think probably the situation was involved . . . new town, new house. . . . A lot of the social withdrawal thing came as a result of the marriage, where my friends were totally unacceptable and so we didn't associate with any of my friends any more.

F continued to describe her interaction with mothers of her children's friends as limiting and unfulfilling. She also described the social pressures of being her husband's wife as limiting and unfulfilling. Circumstances and roles limited F's social context more than her withdrawing from it.

There was no geographical move involved in the other two women's experience of social withdrawal due to circumstances. For D, one circumstance that contributed to limiting her social involvement was her retirement. Many of her friends and much of her social interaction were involved in her work. When that ended, she lost contact with those friends and that social context. K described her circumstance as follows:

> I was being hassled for making so many personal calls, so then I would start making them on my coffee break, which isolated me from a role that I had been playing at work--a social role.

Her social withdrawal during depression was associated with socializing at work and was the product of censure on telephone use. The phone calls were to friends outside of work and were part of her staying in contact with a social context, rather than withdrawing from it.

For each of these women, circumstantial social isolation might be a better description of this part of their depression experience, than social withdrawal.

Getting Sicker / Getting Well. H described social withdrawal as a symptom of either getting sicker or getting well, i.e., getting more intensely depressed or getting over the depression. E described social withdrawal as necessary to her getting better or a symptom of her beginning to come out of the depression experience. Each of these women describe this concept below:

> H: Withdrawal could be to find the space to get sicker. Depends where you're at with it. You could be on the road to healing.
>
> E: In the first stages, I looked outward for solutions, so social in that sense, I guess. But in the latter stages, I withdrew. . . . That was a necessary stage on the way toward getting better, not part of the symptoms of the depression.

In both descriptions, social withdrawal is not portrayed as a symptom of the depression, but a symptom of the intensity of that experience. In the unsaid of some of the other women's conversations, there was an indication that social withdrawal allowed the depression to intensify or reach a point where the women sought help or began some change that led to their overcoming their depression. However, it seems prudent to remember that three of these women sought suicide as their way of overcoming the depression.

Overview of Social Withdrawal. Social withdrawal as a behavior was seen in a number of contexts. Each woman described her social withdrawal during depression in terms of one or more of these contexts. For C, it was circumstance and hiding. For D, it was circumstance, fatigue, hiding, and shame. For E, it was circumstance and a

symptom of her beginning to come out of depression. F and K described their social withdrawal as primarily circumstance. G's social withdrawal was related to circumstance, fatigue, hiding, and loss of emotional control. H referred to hiding, lack of emotional control, getting sicker, and getting well in her descriptions of social withdrawal. For J, social withdrawal was associated with fatigue and shame.

Each of these contexts, then, is descriptive of the depression experience. Social withdrawal is a behavior in response to one or more of these contexts, an observable symptom of the context of the depression, more than a symptom of the depression itself.

Change

A theme of change emerged as these women spoke of their depression experience. Change was described in the context of feelings, behavior, and thinking. While there were other changes that will be presented in the section on outside themes, these were the three areas of change that became identified with the inside of their depression experience.

Feelings. One of the major changes in feelings described by these women as part of their depression experience was an escalation of fear. As noted in the theme of fear above, this feeling of fear was present in each woman's experience. As their fears escalated, their depression intensified. This escalated fear was often described as anxiety. The balance of feelings shifted to imbalance as fear became dominant during their depression. As will be noted in the theme of control below, each woman endeavored to keep her fear or fears in check, in some kind of balance in her life. The use of energy to this end contributed to general fatigue and for many of these women fear grew to anxiety levels.

Another change in feelings during depression was the loss of balance between the light and dark sides of feelings. These women described their depression experience as an increase in dark feelings and a decrease or loss of light feelings. This description of feelings as light or dark seemed to be a metaphor for how they viewed the world and their lives. The light in their world gradually dimmed or flickered and went out. They were left with a dark view of the world, their lives, and their feelings. E and H both spoke of a change in attending to their feelings as a result of their depression

experience. Both women talked about not attending to their feelings prior to their depression, but attending to them now, particularly what E described as "the dark side of feelings." Both describe depression as a time when feelings demanded attention by growing beyond their control. This growth of feelings was a change described by other women as well. Not attending to feelings as they occurred allowed them to accumulate until they were more than the women could handle. These accumulated feelings overwhelmed her and often she found herself unable to identify her feelings or unable to feel.

At one point, H described depression as a void of feeling. She had become numb to her feelings and yet, they were so close to the surface that she occasionally had emotional outbursts. E described her dulled feelings as losing the ability to experience color and texture in her world. Others described it as "losing touch with my feelings" or as paralysis. Some women turned to alcohol or medication to keep their feelings in check before they reached the point of non-feeling. Many voiced their concern that they would be overwhelmed by the feelings associated with depression or would have public emotional outbursts.

In general, change in feelings was described as a gradual increase in feelings they did not want to have and a decrease or loss of feelings they did want to have. There was a tendency to avoid these feelings which were viewed as negative by non-attendance or non-feeling. It seemed to be a case of "If you can't feel something good, don't feel at all."

Behavior. Change in behavior was identified by these women as they described their experience. One change noted above was social withdrawal. C described it as knowing there was work to do, but "all I did was sit and do nothing at home." H described a similar behavior at work:

> At one point I came back from lunch, and I sat at my desk. That would happen lots. Like, I would just sit there and I would stare at my desk and I couldn't work. It was like I didn't know what to do. I couldn't do anything. I didn't want to do anything.

Both C and H, like other women in this study, had exhibited active behavior at home and at work prior to the depression, so this inactive behavior represented a change.

Another change pattern noticeable in the descriptions of the depression experience was the opposite of that above. Many women described a period in their depression when they increased their active behavior. This was often a pattern of staying busy in order to avoid the depression. There seemed to be some rationale that if they stayed busy, they wouldn't become depressed. Perhaps, active behavior was seen as an antidote to attending to their feelings.

As behavior changed, it became extreme. This was particularly seen in crying behavior. G's crying behavior, noted above, became so extreme, she withdrew socially. H describes it as "just forever crying." It was also seen in G's and H's description of their rebellious behavior as depressed adolescents. F described extreme behavior as she struggled to control her environment, while losing control inside. C's extreme controlling behavior drew the response of her son. Regardless of the area of behavior, many of these women described a change from moderate to extreme behavior and from active to inactive behavior or the opposite.

Thinking. Changes in thinking were described in terms of rational and irrational, positive and negative, and ability and inability. H, who described herself as rational prior to her depression, described her thinking during the depression experience as irrational. This change emerged from many of the women's conversations and was most often seen in their behavior. They seemed to change from behavior based on thought or rationale to behavior based on feeling or irrationality.

Another change described was the change in balance between positive and negative thinking or an increase in negative thinking. Using the lamp in my office as an example, E described times before and after her depression when she could look at that lamp and enjoy its design and see it as a useful light. During her depression, she would have seen its design as a cage and lose sight of its usefulness or beauty. This was E's way of describing the change in her thinking during her depression experience. Even when they didn't describe themselves as positive thinkers prior to their depression, many of the women described an increase in negative thinking.

Finally, many of the women described a change in their ability to think. These women voiced concern about their inability to think during the most intense periods of depression. It seemed their ability to think fatigued from the amount of thinking that

occurred in earlier, less intense periods of their depression.

Overview of Change. During our conversations, these women spoke of internal changes that were descriptive of their depression experience. Changes in feelings were described as an escalation of fear, an increase in 'dark' feelings, a gradual non-attendance to feelings, and as becoming overwhelmed by feelings to a point of numbness. Changes in behavior were described in terms of a shift from active to inactive and from moderate to extreme. Changes in thinking were described as a shift from rational to irrational, positive to negative or an increase in negative thinking, and a gradual inability to think. All of these changes were described from within the depression experience.

Control

The theme of control emerged from every woman's conversation in this study and seemed to be a central issue in each experience of depression. From within the experience, control was described in terms of feelings, behaviors, thoughts, and one's life. Each woman wanted to be in control of these things and felt out of control during depression. Control issues involved in feelings, behavior, and thoughts were addressed above as part of the theme of change. Therefore, this section will be limited to descriptions of these women's sense of control of their lives.

Control of her life is very important to C and during her depression, she felt out of control:

> For a time, I felt I was very out of control. Controlling my life or having control of things that happen to me is really important to me. It tends to disappear pretty quickly or it did that time, anyway.

As our conversation continued, C spoke of her loss of controlling her life as part of her sense of helplessness. During her depression, she lost sight of how she lost that control and felt she couldn't do much about it.

For D, being out of control of her life was very frightening. She had observed her husband lose control of his life through mental illness, through his dependency on psychiatrists, and through his hospitalization. Her fear was that her depression was a mental illness and she would lose control of her life in the same way. She described an instance where an adverse reaction to medication caused her to lose control of herself

and her fear rose to panic.

E describes herself as a very controlled person prior to her depression and attributes her depression to over-control:

> Part of my concept of myself is that I have learned so well to be controlled and so conditioned that it's an unfortunate part of myself and something I want to be less! To be a little less controlled.

Being very controlled made it difficult for E to adapt to change and, during depression, she lost control of parts of her life. As our conversation continued, E described balance as important to staying in control of her life:

> What I really would like to have now is just the right kind of balance, equilibrium within, so that I can bend with changes rather than control my reactions to them, even from within.

During depression, F felt out of control of her life, so she tried to control her home environment. Her sense of no internal control led to attempts at external control. For F, being in control of her life meant having choices and during her depression, she didn't feel she had those choices.

G had several experiences of losing control of her life when she was institutionalized. During her depression, G felt the only control she had in her life was suicide. Although not institutionalized, H had a similar sense that she had lost control of her life and she, too, took control through attempted suicide.

K described not feeling effective in important parts of her life and this affected her sense of control in her life. Both K and J talked about needing to control the changes in their lives in order to feel in control. For both, making changes and adapting to those changes were part of their depression experience and part of their regaining or obtaining for the first time a sense of control of their life.

For each woman in this study, the depression experience included a sense of being out of control of her life and a struggle to regain or obtain that sense of control.

Loss

From inside the depression experience, the theme of loss emerges more as a sense of loss, than an external, observable loss. Their sense of loss of self and loss of control were described above. Their sense of lost ability to cope, ability to predict, and

loss of protection will be described below in the theme of helplessness. In this section, their sense of loss will be described in terms of support and belonging, spirit and enthusiasm, physical contact, and direction.

Support/Belonging. Loss of a sense of support and belonging for these women was often related to an event or circumstance outside of their depression. These will be described in outside themes below. Inside the experience of depression, these women felt they had no support or didn't belong, often when support and a place to belong was available to them outside that experience.

C spoke of having her brother and his family available to her for support and belonging, yet, she didn't make use of that opportunity, because she didn't want to burden them with her problems. Later, as she began to come out of her depression, C, like many women in this study, found that support and belonging had been available to her, but she hadn't seen it from inside her depression. The sense of loss and belonging described by these women was usually the result of their concern about burdening others and their limited vision from inside their depression.

One aspect of support for these women was having someone to talk to about their lives. When they were non-depressed, these women could talk to people. When they were depressed, most of these women described themselves as unable to talk to others. The loss of their ability to talk is closely related to their sense of loss of support.

Some of the women had experienced a sense of belonging prior to their depression. They had belonged with other non-depressed people. When they became depressed, they lost their sense of belonging with those people. This was described as social withdrawal above. For two of these women, G and H, searching for a place to belong had been a life-long process. Their sense of loss in this regard seemed to be a loss of the possibility of belonging.

Whether substantiated by events and circumstances outside their depression or not, these women expressed a sense of loss of support and belonging as part of their experience of depression.

Spirit and Enthusiasm. Along with loss of self-esteem and self-concept, these women described their sense of loss of spirit and enthusiasm. Once again, there were

often outside circumstances that contributed to this sense of loss and they will be described below. Inside their experience of depression, they described losing their enthusiasm for things, activities, and life in general. Whatever spirit they had before was broken and lost as they went inside the experience of depression. This loss was noticeable in their fatigue in social withdrawal, changes in feeling and behavior, and loss of control in their lives described above.

The loss of spirit and enthusiasm became most apparent through comparisons of each woman's descriptions of herself and her life prior to her depression experience and during that experience. It was also noted when I compared her description of herself and her life during the depression to my observations and impressions of her in the present. Both comparisons led to my identifying loss of spirit and enthusiasm as descriptive of the theme of loss in the depression experience.

Physical Contact. The loss of physical contact emerged as part of the theme of loss both from inside and outside the experience of depression. From inside, the loss of physical contact was described as an inability to touch or be touched and as a numbness in feeling. E described it as her inability to sense color and texture in the world. H described it in her reaction to a woman at work grasping her arm.

From our conversations, what emerged for me was some connection between physical and emotional feeling. As these women experienced the loss of emotional feeling, they lost the experience of physical feeling. As they avoided attending to emotional feelings, they avoided physical contact. For me, there was the sense that emotional feelings were in tenuous control at some point in their depression experience, and physical contact, such as hugs, would cause them to lose that slender thread of control. At other points in their depression experience, there seemed to be a simultaneous loss of emotional and physical feeling.

Just as there was a conflict between needing to talk and being able to talk, there was a conflict between needing to feel and being able to feel--both emotionally and physically. In most instances, these women described losing the thing they needed most during their depression experience.

Direction. Often exacerbated by external circumstances, most women described an inner sense of loss of direction in their lives. Often they became disillusioned or

disappointed in the direction their lives were going prior to and at the beginning of their depression experience. For some, this was because the direction they had chosen led them to a life that was not what they expected it to be. For others, it was the sense that the direction they wanted their life to follow was blocked in some way. In both situations, they lost direction in their life.

When a woman had a sense of direction in her life, she could be, and often was, active in pursuing that direction. With the loss of direction, there was a loss of activity. Both losses were part of many of these women's experience of depression.

This loss of direction is seen in other inside themes that describe the depression experience: fear of the future and making decisions, fatigue and social withdrawal, change in feeling, behavior, and thinking, loss of control in their lives, and loss of spirit and enthusiasm. It will also be seen in the theme of helplessness described below. It is hard to know which theme came first--even that direction was lost. Perhaps, the sequence was different for each woman. Regardless of where it occurred in the sequence, the sense of loss of direction in her life was part of each woman's description of her depression.

Overview of Loss. As an inner theme, loss was described by a sense of loss of support and belonging, spirit and enthusiasm, physical contact, and direction. Sensing a loss of support and belonging seemed to exist regardless of whether or not support and belonging were available to them. Their reluctance to burden others, their inability to talk to others, their vision limited by the darkness of depression, and their fatigue in searching for support and belonging were all cited as part of this sense of loss.

The loss of spirit and enthusiasm emerged when descriptions of themselves prior to depression were compared to descriptions of themselves during their depression. It also emerged when these descriptions of themselves during their depression were compared to my impressions of them during our conversations. The loss of spirit and enthusiasm also seemed to be affirmed in descriptions of other inside themes of depression: fatigue and social withdrawal, changes in feeling and behavior, and loss of control in their lives described above.

The loss of physical contact was described as an inability to touch and be touched and as a numbness to feeling. There seemed to be an association between

physical and emotional feeling which was noted in the control of one leading to the control of the other and the loss of one leading to the loss of the other. It was also noted that some women described both needing and avoiding touch or physical contact.

The sense of loss of direction in life was described as conflict between what they expected and what they experienced as they pursued a direction in their lives, and between the direction they wanted for their lives and their ability to pursue that direction.

As a theme, loss emerged from both inside and outside the experience of depression. From inside, this theme is described as a sense of loss that occurred regardless of what was occurring outside. This inner sense of loss emerged from the conversations and descriptions for every woman in this study.

Issues

Secrets and unresolved issues seemed to be separate themes in the descriptions of depression given by these women in our first conversation. However, after immersion in the total conversations, descriptions, summary statements, and journal entries, I became convinced that these two potential themes were so enmeshed that one could not be presented without the other. Therefore, they are presented as a unified theme: issues.

During our second conversation, the women in this study were asked to respond to the words, "kept secrets" and "unresolved issues." In response to these words, five women spoke of self-definition and self-blame, five women spoke of their feelings, and three women spoke of fears as issues in their experience of depression. These issues have been described above in other themes. Four women spoke of sexual issues, four spoke of suicide, one of being battered, one of abortion, two of indecision, and two of accumulated issues. Four women spoke of most of their life's experience as secret or unresolved. As can be seen by the numbers of responses, many women had more than one issue that was part of their experience of depression.

Regardless of their diversity and varying degree of seriousness to the outside observer, each was a serious issue for the woman during her depression experience. In spite of their diversity, each issue is bound to the others by common threads: each issue represented something important to the individual, each issue was unacceptable to the

individual, and each issue was perceived as unacceptable to others. Therefore, each issue was kept secret, not talked about, and unresolved.

The importance of these issues to the depression experience is not in their content, but in their consequences. Having to deal with an issue that could not be shared, drove these women further inside. They stepped into that inner space described above in order to deal with their issue by themselves. Not being able to share through talking and not being able to resolve that issue by themselves, closed the door on that space and left them in the dark experience of depression. The unacceptability of their issue was not in their imagination alone. Each woman indicated having learned that that issue was unacceptable. The most often heard statement was, "There are just some things you shouldn't share." Another was, "I just didn't think people could handle it or would like me if they knew." However the learning came about, each woman spoke of her understanding that her issue should be kept to herself and not talked about, even when she knew she needed help in resolving that issue.

Helplessness

From inside the experience of depression, these women described their inability to see any help for their situation. Helplessness describes their view of themselves and their world from that space inside. This view was expressed in two ways: 1) being ineffective or helpless in their outside world was internalized, and 2) being ineffective or helpless in their inside world was externalized. These two perspectives are presented below.

Outside / Inside. During the depression experience, these women describe being inside themselves, but there were things going on outside of that space that were a part of their lives and experience as well. Some of the women described their sense of helplessness inside in terms of their ineffectiveness in these things outside:

> K: Particularly in the work situation. I guess in the marriage situation, too. Like, you did what you thought you could and you were running into a blank wall. There was nothing coming back. You'd get out there and you'd wonder what for.

Functioning and being effective in their outside world was important to these women during their depression. If they could function outside, they could handle their

depression inside. The inside of depression was measured by the outside.

G, H, and J also found themselves ineffective in their outside world and internalized these experiences as helplessness inside. They internalized a sense of helplessness in handling their depression, as well as in being able to overcome their depression. All three of these women had a lifetime of experiences that taught them that they were helpless. For G, some of these experiences were being a child in an alcoholic family, trying to adapt to the many geographical moves in a military family, being institutionalized by her mother at age 13, and being released from that institution with the diagnosis of still needing help. All of these experiences and others were internalized by G as her inability to do anything about her depression.

Although not institutionalized, H had similar experiences. She had been unable to stop the abuse of her father, to get her mother's positive attention after her parents' divorce, to find "Mainstream, U.S.A.," to avoid pregnancy and abortion, and continue functioning at work. In each experience, H felt she was helpless and, therefore, felt helpless in her depression.

J was born with a physical disability, which carried with it a degree of physical helplessness. In addition, she felt helpless in her doctors' and parents' decisions about her surgeries and hospitalizations. She grew up in the protection of her family and her depression was focused on her conflict between gaining independence and giving up that protection. J described her struggle to overcome her sense of helplessness that she had learned in her outside world and had taken to her inside world of depression.

Each of these women described doubting their ability to be effective in dealing with their depression inside. For some, that doubt grew to certainty that they were helpless in coping with or overcoming their depression. That doubt was fed by their experiences in their outside world before and during their depression experience. For these women, outside helplessness was an indication to them of their inside helplessness.

Inside/Outside. Other women described their helplessness in their outside world in terms of their sense of helplessness in their inside world. These women were struggling with their feelings, feeling helpless to do anything about them, and expressed their inner sense of helplessness as confusion in their outside world.

> F: Not knowing what to do and not knowing how to get help. Just not knowing. I felt like there should have been somebody who could tell me that I was having problems. . . . The situation was sort of hopeless.
>
> E: The very worst stages of depression when there was definitely a strong physical component as well. A short period of total inability to make decisions, to get all the way through a small chore, the remembering what the hell it was you were supposed to be doing and not stopping and crying in the middle of it.
>
> C: The feeling of, "I'm in this situation; there isn't very much I can do about it and I don't even know how I got there or how I'm going to get out or how I'm going to handle it while I'm here." It's frightening. It's really not understanding it at all.

In other parts of our conversations, these women described their inability to figure out what was happening to them inside. Their descriptions were often expressed in terms of not knowing: not knowing how they got depressed, not knowing how to cope with their depression, and not knowing how to get out of their depression. F even described not knowing she needed or could get help with her depression. These women were helpless with their depression and confused by it.

The helplessness and confusion felt inside the experience of depression were projected externally. They became helpless and confused in their outside world. D described her helplessness as feeling like a child:

> I felt like a child who is still dependent on his mother to look after him, protect him, love him, and look after him physically, except that I was an adult, and as an adult, I should be able to look after myself.

For these women, being helpless in their outside world was not so much being ineffective in what they did, but was not knowing what to do. For these women, helplessness inside their depression was reflected as confusion and indecision in their outside world.

Summary

The eight themes above present a picture of the inner space of depression, the inside experience of depression as it emerged from conversations with the women in

this study. That space was described as a focus on "self," fear, isolation, social withdrawal, change, control, loss, issues, and helplessness.

The focus on "self" was described by self-definition, self-esteem, and self-blame. During the depression experience, these women were struggling with defining or re-defining themselves. Many of the women had reached a point in their lives where they either had lost touch with themselves or became dissatisfied with themselves or both. Some spoke of not knowing who they were. Some spoke of not being who others thought they were. Some spoke of not being who they thought they were. Others spoke of not being who they thought they would be. For all of the women, it was important to have a self-definition that was acceptable to them and to others.

No matter whether their definition came from others or self, these women were questioning the value of that defined "self" to themselves and to others. In most women's experience, the value that they perceived at the time of the depression was low or non-existent. Most women held a negative view of their value and that view was perpetuated or exacerbated by their depression; having depression meant they were less valuable than non-depressed women.

In addition, some of these women blamed themselves for being depressed. Many also blamed themselves for the negative experiences that they associated with their depression. For many women, their definition and value were viewed negatively and their self-criticism and self-blame perpetuated that negative view. During the depression experience, the focus on "self" was seen through a negative lens for most of the women.

The inner space described by the women in this study held many of their fears. Perhaps because that space was small and dark, these fears often appeared to them during their depression experience in exaggerated form. While some women described fear as generalized to anything and everything, others described specific fears: fears of non-acceptance, fears of being overwhelmed, fears of being different or not normal, fears of hurting others, fears of dependency, fears of the future, and fears of making decisions. During our conversations, every woman spoke of fear as an important factor in her depression experience, particularly the fear of depression, and for many women,

their fear reached an intensity that seemed overwhelming or paralyzing.

Isolation was described as a feeling of being cut-off from others and the outside world. These women described a heightened sense of being alone in their world during their depression experience. As they focused on their inner space, they expressed a sense of not experiencing connectedness or togetherness in this world and their inability to connect with others through talking about their depression and its issues.

Social withdrawal was described as a behavior in response to the context of depression. Often, circumstances in these women's lives removed them from their social context and these will be discussed below in outside themes. As an inside theme, social withdrawal reflected feelings of fatigue, of shame or a need to hide, of not being able to control their emotional responses, or of needing to be alone in order to get more depressed or better. Social withdrawal was described as an outside, observable behavior that reflected the inner feelings and thoughts of these women during their depression experience.

Change emerged as both an inside theme and an outside theme. As an inside theme, change was described in terms of feelings, behavior, and thought. Changes in feelings were described as an escalation of fears to the point of anxiety, an increase in the dark side of feeling and a concomitant decrease in the light side of feeling, and an increased attention to inner feelings. Attending to and controlling their feelings took a lot of these women's energy and they described gradually fatiguing or going numb to their feelings during the depression experience. Overall, change in feelings was described as an increased awareness of their feelings and a gradual fatigue in attending to those feelings.

Change in behavior was described as a shift from moderate to extreme behavior and from active to inactive behavior or the opposite. Crying and controlling behavior were most often cited as examples of this change. As with social withdrawal, change in behavior was a response to change in inner feelings.

Changes in thinking were described in terms of shifts from rational to irrational, from positive to negative, and from ability to inability. Women who described themselves as rational thinkers prior to their depression experience described their thinking as irrational during that experience. These women also described an increase in

negative thinking, often to the point of not being able to think of anything positive when they were depressed. In addition, these women described a change in their ability to think. Several described an inability to think during their depression experience.

Control also emerged as both an inside and outside theme. As an inside theme, control was described in terms of feelings, behaviors, thoughts, and one's life. Each woman spoke of wanting to have a sense of control of these things and, yet, having a sense of being out of control during her depression experience. Much of the fatigue during depression was attributed to the energy it took to exercise control in these areas. Many of these women also described trying to make their world smaller by going inside in order to maintain some control. Descriptions of struggling to regain or obtain a sense of control in her life was part of every woman's conversations.

As a theme, loss emerged from both inside and outside the experience of depression. As an inside theme, loss was described in terms of support and belonging, spirit and enthusiasm, physical contact, and direction. Each of these things were important to the women in this study and they carried a sense of having lost support, enthusiasm, physical contact, and direction during their depression experience.

The theme of issues was described in terms of secrecy and non-resolution. Regardless of content, each issue represented something important to the individual, something that was unacceptable to the individual, and something each woman perceived as unacceptable to others. Therefore, each issue was kept secret, not talked about, and unresolved. The importance of these issues in the depression experience is described more by their consequences than their content. Each woman described having learned or come to an understanding that these issues were not acceptable and not to be shared with others. Therefore, these women did not recognize or seek out help that was available in resolving these issues during their depression experience.

The theme of helplessness emerged in two perspectives: 1) being ineffective or helpless in their outside world was internalized, and 2) being ineffective or helpless in dealing with their internal struggle was externalized. Those women who had the first perspective had experienced frustration and helplessness in their external environment and adopted a sense of themselves as helpless in both their outer and inner worlds during depression. The women who held the second perspective felt a sense of

helplessness in controlling or resolving their inner feelings, thoughts, and issues and expressed that sense of helplessness as confusion in their external world. Regardless of the perspective, the results were the same: each woman described herself as helpless in both her inner and outer experience during depression.

Outside Themes

The following themes describe depression as it was experienced in the outside world of the women in this study. During our conversations, these women spoke of external circumstances and experiences during the time that they were depressed. This outer world was viewed through the lens of their depression; therefore, it reflects their perception of that outer world and describes another view of their depression experience.

One theme emerged as an outside theme alone, while four emerged as both inside and outside themes. Social context emerged as an outside theme that complimented the inner theme of social withdrawal. Change, control, loss, and helplessness have been described in terms of internal experience . Here, they will be described in terms of external experience.

The outside world of a depressed woman can be observed by others, as well as the woman herself; however, these observations can present two different perspectives of that world. The observations and perspective of the depressed woman are described by the themes presented below.

Social Context / Circumstances

Either prior to or during the depression experience, each woman described a circumstance that changed or took away the social context they had known. Four women described a geographical relocation that separated them from the social contacts that were familiar to them or prevented them from establishing social contacts. Two women described a change in their sexual identity that changed their social context. One woman described retirement from work as cutting her off from the social context she had known and her husband's death as changing her social context as a married woman. Another woman described losing the social context of her family as she explored her independence. Change or loss of social context, regardless of its circumstances, was

thematic in each woman's description of her depression experience.

In their reflection on their depression experience, not all four women recognized their geographical move as a major part of their depression. Yet, in every case that move impacted their social context which was a part of their depression experience. The descriptions of social context and circumstance for these four women are presented below.

C moved to Canada from another country and culture just prior to her depression. She described having a social context in that country that she did not have in Canada:

> I did have some very close friends in [ ] whom I missed a great deal. People with whom I shared a common situation. . . . These friends were my first really close women friends--a landmark in my development--and very hard to leave behind, perhaps never to see again.
>
> When I first moved to Edmonton, I wrote letters to . . . friends--a massive effort at human contact. A few months later, I wasn't capable of doing that. I would think about it, but just wouldn't do it, even when I had lots of time.

Not only did C lose the social contacts that had been important to her, but she found herself in a social context she perceived as threatening to her self-esteem. She described her sense that she would have to compromise her values and beliefs in order to be accepted in this new social context and this was something she was not prepared to do. As a result of her relocation, C lost her social context and was blocked from developing a new context. Although C did not recognize her geographical move as an important factor in her depression, her loss of social context as a result of that move was described as an important part of her depression experience.

As noted above in inside themes, G experienced many geographical relocations during her life. She describes frequently having to adjust to new social situations and feelings of isolation, fear, and helplessness at that time. For G, depression included a sense of having no social context as a result of the many geographical moves in her life. Like C, G did not seem to recognize these moves as important in her depression, but did recognize her isolation, fear, and helplessness (which were in part related to her lack of social context) as important factors in her depression experience.

Both E and F recognized a change in social context as a factor in their geographical relocations and, consequently, in their depression experiences. For E, it was a move from Canada to the United States; for F, it was a move from western to eastern Canada. For both women, it was a move away from established friends and social context. As E remarked in her citation about social withdrawal above, the move separated her from familiar social contact and she really didn't have time to establish new social contacts before she became depressed. This loss of social contact did not cause her depression, but did add to it. In F's description, the move to a new city represented a loss of friends and support which contributed to her depression. Whereas she perceived her previous social context as supportive, she perceived her new social context as lacking support. Both women spoke of geographical relocation as a factor in both their loss or change in social context and their depression experiences.

Both J and H spoke of a change in their sexual identity as a contributing factor in the change of their social context. Neither spoke of this change in social context as an important factor in their depression. H describes her coming to a recognition and acceptance of her identity as a lesbian as a factor in her recovery from depression. In some ways, this identity gave her the social context, the sense of fitting in, that she had been searching for. It might not be Mainstream, U.S.A., but it was a social context in which she found acceptance and support.

J described her discomfort with trying to gain acceptance and recognition from men in the social context of heterosexuality. During her exploration of who she was and what she could do that was a large part of her depression experience, J found some comfort by giving up her identity as a heterosexual and accepting her identity in the social context of homosexuality. During our conversations, both H and J described their identity as lesbians more in terms of a social context than as a sexual practice. For both women, recognizing and accepting themselves as lesbians did not cause or contribute to their depression, but did contribute to their overcoming depression by accepting a social context in which they felt accepted.

J also experienced another change in social context during her depression experience. Part of the ambivalence that was a large part of her depression experience was in making a decision to leave the social context of her family. Becoming

independent meant moving out of the social context of her family which had protected her from dealing with things in the outside world and had allowed her to remain an innocent, naive child. Both being dependent and independent were described in terms of social context and J felt ambivalent about choosing one at the loss of the other. J spoke of both her comfort and discomfort with her familly social context. This aspect of social context and its accompanying ambivalence were a central part of J's depression experience.

For D, her retirement from teaching separated her from friends and a familiar social context. Most of her social context was associated with her workplace and that was lost when she retired. Although on anti-depressants during the last year of her teaching, D did not speak of that period as depression because she was functioning and had social contact. However, after retirement she lost both that aspect of functioning and contact. It is that period after retirement that D describes as her depression experience. Although she did not speak of this loss of social contact and context as an important factor in her depression, she did speak of the importance of talking and having support during the depression experience. D did not talk and did not have a sense of support during her depression, so it seems reasonable that social context was an unrecognized, but important aspect of that experience for her.

For seven women in this study, there was an observable change in or loss of social context. For each of them, social context was a factor in their depression whether or not they recognized its significance at that time. The way they viewed themselves socially during the depression experience emerged from their descriptions of that experience and contributed in some way to their depressed state or their overcoming their depression.

Change

During our conversations, external changes in the lives of the women in this study were part of the way in which they described their depression experience. Each woman described these changes in terms of the context of their lives just prior to and during that experience. During their depression, some of these women were aware of the importance of these external changes to their experience, others were not. However, in every conversation, outside change emerged as a theme of their

depression.

These changes were described as geographical, sociocultural. work, relational, activity, and physical change. Geographical and sociocultural changes were presented in the outside theme of social context; therefore, the following descriptions will focus on the other aspects of change; work, relationships, activity, and physical change.

Five women described changes involved with their work as important factors in their depression. D's work as a teacher had been part of her self-definition. When she retired, she lost her definition as a working woman. Similarly, E left her work as a teacher to accompany her husband to graduate school. She, too, lost her definition as a working woman. For both women, teaching gave them a sense of direction in their lives and an active, busy schedule. Both described a loss of direction, a change in their definition, and a change in their activity level occurring as a result of their work role ending. These changes were experienced just prior to or at the beginning of their depression experience.

During our conversations, K described changes in her work situation as directly related to her depression experience. She described pressures at work and her difficulty in dealing with her boss as contributing to her sense of incompetence and fraudulence. As these pressures and difficulties escalated, so did her depression. These changes at work were outside of K, but were internalized as helplessness, fear, isolation, and other aspects of her depression experience.

Changes in her work situation both contributed to C's depression and helped her to overcome her depression. C experienced a change from a working professional to a graduate student. As a professional, C had experienced herself as valuable and competent in her work. As a student, C's sense of her value was perceived as threatened by the competitiveness of her situation. She described it as "a blow to my self-esteem." It was in this work context of student that C experienced her depression. When she re-entered the professional work force, C experienced confirmation of her value from co-workers and described this experience as a contributing factor in her recovery from depression.

G described a life of many changes and frequent depression from adolescence to the end of her last depression experience five years ago. Part of these changes were

related to work. During those years, G had been a student of various kinds and had changed types of work several times. Although G did not describe change in work as an important factor in her depression, it emerged as a part of the overall theme of change which was prominent in her description of her depression experiences.

Changes in relationships emerged as part of the outside theme of change for six women in this study. C and D both experienced this change when their husbands died. C describes her sense of loss in this regard as being balanced out by her gain in independence and control. For C, this change in relationships was not perceived as contributing to her depression experience. D describes the loss of her husband as the loss of her definition as a married woman. In addition, D spoke of growing up with the perception that women are defined by their husbands, so this loss of definition seemed important to her. D also described changes in her relationships with her children as a result of her husband's suicide and her depression. All of these relational changes were described as important factors in her depression experience.

H described her relationship with her fiance and their eventual break-up as part of her depression. This relationship included physical and emotional abuse for H as she described not wanting to get married, but feeling her mother's pressure to conform. For H, the end of that relationship confirmed her sense of not fitting society's norms and contributed to her depresion.

During her depression experience, E described a relationship with a man outside of her marriage as an important part of that experience. She described being confused by the feelings that that relationship generated. E described her depression as a struggle with her feelings and this change in her relationships generated feelings that were a part of that struggle.

K experienced several changes in relationships during her depression experience. One change was her divorce from her husband. Others were relationships with men that eventually failed to endure or be fulfilling for K. Part of K's description of her depression was her struggle to have a successful relationship with a man. She spoke of her helplessness in terms of both work and these relationships.

J talked about her struggle with independence and dependence as a large part of her depression experience. Relationships, particularly with her family, were often

described as dependent. J spoke of her need to have a one-on-one relationship as a conflict with her need to be independent. This conflict was described as an important issue in her depression. For J, her depression was not described in terms of a change in relationships as much as in terms of a change in her perception of relationships. She described losing relationships with friends, because of her "neediness" and dependence. Part of her struggle to become independent was to avoid losing her relationships with friends, but her lack of relationships outside of her family left her alone in her struggle and in her depression.

The physical aspect of change emerged from conversations with two women. J had lived all her life with a physical disability and her description of her depression experience included her challenging that disability through physical exercise and independent living. Her sense of disability contributed to her depression. As she challenged this disability, she began to sense her ability to physically protect herself and physically cope with independent living. Her sense of ability and being capable were described as part of her overcoming her depression.

H experienced the physical changes of pregnancy and abortion at the onset of her intense period of depression. These physical changes represented conflict and helplessness for H at that time. She did not want to be pregnant or have children, yet, she did not want to have an abortion either. She described her frustration in trying to resolve this conflict. Both physical conditions were unacceptable to H. Her eventual abortion contributed to H's sense of her unacceptability and to her experience of depression.

Each of these changes occurred in the outside world of the women in this study. For some, these changes occurred during their depression experience and were perceived through the lens of depression. For others, these changes occurred prior to the depression experience and were part of the onset of that experience. For a few, these changes were associated with their overcoming their depression. Regardless of when, where, or how these changes occurred, the theme of change in these contexts emerged from these women's descriptions of their depression.

Control

Control as an inside theme looked at the inner feelings, behaviors, and thoughts, as well as the sense of control in their lives, in these women's described experience of depression. Control also emerged as an outside theme descriptive of the events and circumstances surrounding these women during their depression. Each woman expressed her need to have some sense of control over the things outside her that affected her life and each described a sense of loss of control over these things during her depression experience.

Having control over what happens to her is important to C. During her depression, C described her sense of things happening in her situation that were out of her control. An advisor had taken control of the courses C was to take as a graduate student, and the load was too great for C at that time. In addition, C felt she had no control over the social context she found herself in as a student. For C, control meant being able to predict what would happen to her, but she had not predicted the problems she experienced as a student. When her situation turned out to be different from what she had predicted, C lost her sense of control in what happened to her and became depressed.

D described being in control of her life as "essential." She had survived a chaotic marriage situation by exercising her control of that situation. She had controlled difficult classes of children. She had observed her husband lose control over his life when psychiatrists had him institutionalized. During her depression, D described her anxiety about becoming so depressed that she might be institutionalized and lose control of her life in the same way. She had no sense that she could control what psychiatrists and the medical community could do to her if she didn't control her depression. Staying in control of her depression meant she could stay in control of that situation in her outside world.

F equated control with having choices. She spoke of not feeling that she had choices in her outside world. F found her choices in the outside world limited by the role stereotypes that were part of her life at that time: wife and mother. "I didn't know what choices I had." Her suicide attempt was her attempt to exercise some control over her life, but it failed and the psychiatrist sent her back to the situation she had tried to

escape. She described eventually gaining some control over her life through the choice of divorce. In our conversations about the present, F described having choices as giving her a sense of control and helping her avoid any further depression.

G experienced the loss of control over every aspect of her outer world during institutionalization for depression. She described trying to learn what to say in order to gain her release from institutions and gain some control over what happened to her. Throughout most of her life outside, G had little sense of control over what happened to her. She described others as having that control. She, too, tried suicide and ended up back in an institution when that attempt failed where, once again, others were in control. Many of these experiences seemed to contribute to G's pervasive and persistent sense of no control in her outside world and were described as important aspects of her depression experiences.

During their depression experiences, H had no sense of control over the abuse of her father and fiance, over her pregnancy and abortion, or over her being different than those in her outside world; K had no sense of control over the state of her personal relationships; and J had no sense of control over her physical vulnerability in the outside world. For each of these seven women, having a sense of control in the outside world, especially in the way it impacted their lives, was important and, during their depression experience, they did not have that sense of control.

Loss

As an inside theme, loss was addressed as a sense of loss that was a part of the inner experience of depression. As an outside theme, loss emerged from these women's descriptions of what was happening around them or to them just prior to or during their depression experience. Loss of social context, work, relationships, activity, and control have been addressed in other outside themes. In this section, an overview of each woman's description of loss in her outside world will be presented.

C did not acknowledge loss as important to her depression experience, yet, her conversations describing that experience referred to several losses in her outside world. She lost her husband, her security and safety in a foreign country, her professional work situation, her social context, and eventually, control over external events and circumstances that impacted her life. During her depression and in

retrospect, C's losses in the external world were not recognized as important and, yet, she included those losses in her description of her depression experience.

D described not being aware of loss in the outside world during her depression experience. However, her description of that experience included several losses: her husband's death, her retirement from work, her loss of activity, her loss of social context, and her loss of contact with her son. H also described loss in the outside world as obvious in her experience of depression, but described loss of control over her physical person through pregnancy and abortion, loss of her job, her father's death, and loss of her relationship with her fiance as she spoke of her depression.

E described ungrieved deaths of friends and relatives in the three years prior to her depression as part of that experience of loss in the outside world. She also spoke of her loss of work as a teacher, loss of activity and busyness in her life, loss of social context, loss of resources, and loss of contact with young people as part of her depression. Becoming aware of and accepting her feelings was described by E as the main focus of her depression and each of these losses contributed to those feelings.

F equated loss with external change in her life. Primarily, geographical change brought about the loss of social context, friends, and support network. For G, frequent geographical change represented the loss of opportunity to develop a social context, friends, and support network. In addition, both of these women lost some control over their lives at the hands of psychiatrists and institutions.

I described loss in her outside world primarily as the loss of relationships. However, her description of her depression experience also included loss of control in her work environment and loss of social context. J described the loss of her job as important in her depression. The loss of her job was associated with her sense of loss of importance, power, and control. J also described losses of social context, friends, and the protection of her family as important.

In their descriptions of the experience of depression, each woman in this study spoke of loss in their outside world. Some women acknowledged these losses as factors in their depression experience, others did not. Although loss in the outside world was part of each woman's description, there seemed to be a dichotomy in the perception of the importance of these losses to the experience of depression.

However, both views reflect the way these women perceived outside loss from inside their experience of depression.

Helplessness

Helplessness emerged as an outside theme for five women in this study. Three spoke of learning helplessness in systems or institutions and two spoke of learning helplessness both in systems and in socialization. Within their descriptions of their depression experience, each woman described how she learned she was helpless in her outside world.

J described her experiences with medical institutions and the medical system as a result of her physical disability. Through these experiences, J learned that she was helpless in the choices made by others to have her hospitalized for further surgery. Also, through their emphasis on her disability, these institutions and systems taught J to perceive herself as helpless in the outside world. Each operation was described as an effort to make her "just a little bit better," just a little less helpless in the outside world. J grew up with this perception of herself and it was this perception that contributed to her doubts that she could live an independent life and contributed to her depression. The medical system had labelled her somewhat helpless in terms of her physical condition and it was J's challenge of this perception that was an important part of her depression experience.

D had observed her husband's helplessness with his mental illness and the medical system that labelled and institutionalized him. Part of her fear of the medical system was based on this observation. She had learned that depression is a mental illness and that mentally ill people are helpless in the medical system. This fear of being helpless in her outside world was part of her depression and learned through her observations of her husband's systematized helplessness in that context.

C's experience with the university system was described as part of her depression and part of her learning that she was helpless in that system. As a result, she felt helpless in challenging unfair assignments and the competitiveness between students in classes and her advisor's choice of course load. Part of her description of her depression experience was her helplessness in the university system.

Both F and G learned that they were helpless in the medical system when they were hospitalized or institutionalized for depression. In each case, the hospital or institution rendered them helpless after their suicide attempts failed and after their release by sending them back to the same outside world that had led them to those attempts. G, in particular, noticed her helplessness while in those institutions and took that perception of herself as helpless to both her inside and outside worlds.

In addition, both F and G described their helplessness in the outside world as part of their socialization. F described it in terms of social roles she had learned. As a wife, she was helpless in the face of her husband's power over the choices that impacted her happiness or depression. G described it as observing her mother's helplessness in her marriage and as being "raised to be powerless." Both described the socialization of powerlessness or helplessness as part of their experience prior to and during their depression experience.

Summary

Outside themes presented in this chapter described social context and circumstances, change, control, loss and helplessness in the outside world of these women as they viewed it from inside the experience of depression. Sometimes several of these themes emerged from a single event such as a geographical move. Relocating geographically was viewed as a separation from a familiar social context, a change of environment, loss of friends and support network, and an indication that the woman had no control over what happened to her. Change in working conditions or the loss of a job was viewed in a similar manner.

The theme of social context and circumstance was presented as a type of forced social withdrawal. Geographical moves, changes in sexual identity, retirement, death of a spouse, and moving out of the family home were all described in terms of a change in social context. Each event in the outside circumstances surrounding these women just prior to or during their depression had an impact on each woman's social contact. Some women recognized this impact, others did not, but each woman spoke of these events as an integral part of her description of her depression experience.

The theme of change in the outside world also included the changes described above. In addition, these women spoke of changes in relationships, activity, and physical

being. Events that changed relationships were death, divorce, broken engagements, and burn-out. While each of these events represented a loss of relationship, one woman described a new relationship with a man outside of marriage as an important factor in her description of depression. Changes in activity described by these women were either an increase in activity in the outside experience or a decrease. In both cases, the change in activity was related to the experience of depression. Physical aspects of change were described by two women. H experienced an unwanted pregnancy and abortion. J experienced a change in her ability to function independently in the world with a physical disability. For all of the women, changes in their outside environment and circumstances were a part of their description of their depression.

Each woman expressed her need to have some sense of control over the things outside her that affected her life and each described a sense of loss of control over these things during her depression experience. Each described events in her outside world that were out of her control and each of these events had a negative impact on her inner world. One woman described not knowing she had choices in her outside world and therefore, had no control in that world. In some way, each woman had experienced a situation where she had no control in the outside world and this seemed to add to her sense of losing control inside the experience of depression.

As an outside theme, loss emerged from these women's descriptions of what was happening around or to them just prior to or during the experience of depression. Each woman spoke of loss in her outside world, but not all of them acknowledged that loss as important to the depression experience. However, none of them could describe depression without referring to those losses.

As an outside theme, helplessness was described as being learned through socialization or through experiences with systems and institutions. Those women who had been institutionalized or observed the institutionalization of someone close to them learned that they were helpless in that system and expressed their fear of losing control of their lives to that system. Two women spoke of learning social roles that left them helpless in their outside world. They spoke of being raised to be powerless. In addition, their observations of women who lived these roles, i.e., wife and mother, and the helplessness they observed in other women confirmed their own sense of helplessness.

Through these observations, these two women learned to be helpless in their outside world.

Throughout all the descriptions of depression there seemed to be a link between inside and outside themes. Changes in social context or circumstance seemed related to social withdrawal for many of these women. In general, changes in a variety of circumstances in their outside world precipitated or exacerbated changes in their inside world. Loss of control over their thoughts, behaviors, and feelings inside were related to loss of control in their outside world. Loss in the outside world seemed to be associated with a sense of loss inside. Experiences of helplessness in their external circumstances seemed related to their sense of helplessness in their depression. It was not always possible to determine whether these themes expressed themselves in the outside before they were a part of the inner experience or vice versa. Perhaps, they expressed themselves as themes in both worlds simultaneously. Whatever their order of emergence, inside and outside themes seemed to be related to each other in some way and both seemed necessary to complete the description of these women's experiences of depression.

B. Metaphors

The themes presented in this chapter describe women's experience of depression as it emerged from conversations with the women in this study. That description can be enhanced by listening to these women's words as they respond to my question in our second conversations: How does it feel to be depressed? As they answered this question, these women spoke in terms of physical and visual equivalents and opposites, as well as in point form. Using their terms and their words, this section describes how depression feels.

Many women spoke of physical feelings that described their inner experience of depression. Words like "heavy," "sluggish," "slow," and "paralyzed" are found in their descriptions:

> C: Heavy. That's a physical kind of thing. Almost as though every limb weighs twice as much and your midsection about ten times as much. Sluggish and very heavy and scared. . . . The heaviness seemed to be the thing that I

noticed the most. It was almost being weighted down by something within myself. Not something on my shoulders, but something inside that was sort of pulling me down.

I: Paralyzed!

E: Physically felt heavy and slow.

G: This huge heaviness that I felt . . . the big lump in the pit of your stomach.

Other women described it as "being physically cut off from the world," "closed down," or dulled to physical feeling. J described it as a cocoon:

I had one anxiety attack that was so bad that I felt like, if I had a knife in the room, I would have tried to slice myself open. It sort of felt as if I was covered in layers, sort of going into a metamorphosis and covered in layers of sticky fluid. If I could cut through this sticky fluid and let my real self out or let myself out of this mess, cut my way out of it, that I would be fine and I could step out of it. Sort of breaking out of an egg, maybe a butterfly . . breaking out of its cocoon. That's sort of how it felt. It wasn't a dark cocoon. It was sort of a clear glue, so I could see what was going on out there, but I couldn't get in contact with it and carry out what I wanted to do.

I described feeling like she was "crammed with cotton wool," which made it hard for her to do things. She also described a recurring dream from that period in her life in which she couldn't make her hands move fast enough to do things and she couldn't make herself speak. She presented this dream as her metaphor for how depression felt.

E described the first stages of her depression as her feeling like she wanted to move and be physically active. She described her later stages as "feeling slowed down and lethargic," "the muffled feeling." She also described feeling unable to experience color and texture in things. Her metaphor for feeling depressed was "a grey fog":

The grey fog everywhere. I cried in the mornings and later in the day and still felt the greyness was still there. . . . Sort of a blanket of fuzz, a fog.

Each of these women are describing some sense of not feeling or being cut-off from physically feeling things. For F, this feeling reached the point of almost feeling dead:

Closed down. Sad. Dead. Except it's not quite dead, 'cause you feel so

> awful. Scared. Inadequate. Insecure. Dull and just closed up. Closed, for sure!

Similarly, G describes it as a "deadening." Her description presents a good example of the negative view of the future expressed by many of these women:

> Bleak. A perfect word for how I felt all the time. Just completely bleak. There was nothing to look forward to. My life was just worthless. Never being happy. Ever! About anything. Even when I wasn't really depressed, just not being really happy about anything. Wanting to try all these new experiences, but just thinking, "What's the point?" It was just sort of a pointlessness of everything.

In addition to her cocoon metaphor, J also described her depression in terms of a whirlwind:

> It's sort of like being in the whirlwind tunnel, where you're being pulled down to where all your self control is being pulled out of you. You're just fighting to stay at the top so that you're not pulled right down and right into it and out of control.

Continuing, J describes the view and feelings from within the eye of her whirlwind:

> You can see what's going on outside and you want to be part of it, but until you get through the mess you can't get to that part.

For H, whose "black hole" was similar to J's whirlwind, no description could be adequate to describe how depression felt for her:

> Maybe there's no way of actually describing how bad it was. I mean, it was bad! It was awful. Worse than awful. It was that deep. An infinity of deepness. I think I saw it as this huge thing and that even telling anybody about it would be overwhelming, unbelievable.

D spoke of her feelings of "utter despair" during her depression experience. She also talked about going "down the drain," feeling lonely and isolated, not talking to people, and not having patience. In her written comments, she described depression in point form:

> Being depressed is: 1) being angry at the world, 2) a great deal of frustration and hostility sometimes for no apparent reason, 3) not being able to get a

> good night's sleep for sometimes months on end, 4) losing one's self-esteem, 5) not having any energy to do your work, 6) isolating one's self from friends and community, 7) being very confused, 8) feeling as if you are a second-rate citizen, 9) having difficulty in remembering things, and 10) not being able to function properly in one's work.

Like D, many women used their ability to function in the outside world as an index for the depth of their depression. At its greatest depth, they described not being able to function.

Two women described feelings that they associated with the opposite of depression. F described anger as the opposite of depression:

> It's really funny, 'cause part of the feeling words of being not depressed would be angry. Which is kind of silly, isn't it? Being able to be angry about a lot of it and to direct it got me over a lot of the stuff.

At one point, C described the opposite of depression and then gave a short description of feeling depressed:

> The idea of being light, flying and gliding like a fish. Moving easily in my life. The depressed side of that would be really heavy, slow, uncoordinated types of things.

Feelings are sometimes hard to describe; yet, each woman managed to give me a sense of what their depression felt like for them. Their images of a clear, sticky cocoon, a whirlwind tunnel, a grey fog, a black hole of infinite deepness, a blanket of fuzz, cotton wool and a drain, gave me a sense of their isolation and dulled senses during their depression experience. There seemed to be an understandable contradiction of feeling too much and not feeling at all that was similar to my own depression experience. These images also described depression literally as being pressed down, so that it was difficult to move or be effective in their lives at that time.

Some of their words described both physical and emotional feelings. Physical feelings of heaviness, sluggishness, lethargy, paralysis, and being slowed down described their emotional feelings as well. Living with these feelings led many of these women to utter despair and a bleak view of the present and future. As they spoke, I felt their giving up in the face of the depth and weight of their depression. As they spoke, I

felt their depression as I had felt my own.

C. "Tell Women Who Are Depressed . . . "

Perhaps the best summary description of the depression experience is found in these women's words to depressed women. Each woman in this study expressed a desire to help others. They wanted their experience to have meaning for others as well as themselves. Through their words to women who are depressed, these women speak of the meaning that experience had for them, the things they needed to know when they were in that experience, and the things they think we all need to know about depression. There is no attempt to interpret their words. Here the women speak directly to other women. During the process of this study, these eight women had been on a voyage back to their Land-of-Experience and had returned to the present. With that experience fresh in their minds and feelings, these women tell women who are depressed:

> E: Welcome! Don't be afraid of it. It's not just an illness that some of us avoid and others don't. If it really is because of the way we're socialized and brought up, get over that and become integrated within yourself. Some variations or degree of depression may be a necessary step--our way of buying ourselves the time to do internal work. We don't deliberately do it, but we can go around saying, "I'm sick. Now you have to leave me alone until I've sorted this out." Depression may be part of life's process and not a mental illness--part of coming to terms, coming to be able to define ourself instead of living by the definition of others. Whether it's just a way of buying time or whether our emotions need to fall entirely apart before they can be reintegrated, I'm not sure. I find I'm definitely reacting more and more against thinking of it as illness.

> K: It's funny. It's probably the opposite of what I would have said a while ago. I saw a TV ad not long ago about mental health, about what to do when people are acting strange ways. You should go in and hassle them to get out of bed. Right? "Come on, kid. Get off your ass and do something. You'd feel

a lot better if you did something." That's probably what I would have said and probably did say to myself a whole lot. Now, I would probably say, "Tell the world to 'fuck off' and just leave you alone and try to figure out what it is that you want and you need. You're probably going to feel like you need somebody to help you figure out what that is--at least for a while. So find somebody that can help you figure out what those things are. It's important to talk about something that's bugging you. Don't let anyone rush you through it. Find a safe place to talk it out. Somewhere we get the message that we aren't going to be able to manage our own lives, that we're going to have to be dependent on somebody. That's not true! Take the time to figure out what you want and you need and tell the world to leave you alone while you're doing it. (I've never verbalized any of this before. Talking to someone helps you verbalize things and figure them out.)

D: If they are depressed, I think no matter what people say or do around their own area, they should definitely seek counselling. I know it can be quite difficult. I think it was a bit difficult for me in the sense that I could foretell the comments some of my neighbors would make. But, I went ahead anyway. So, I think the really important thing is to get someone to talk to. And if they can't get counselling by a psychologist, then talk to a friend. Talk to their parish priest or minister or whatever, but they should talk to someone, talk about what's wrong in their life and what they can do about it. I think I even mentioned that a feminist psychologist would most certainly be important, because I think that they would know more what the person was going through. I think the psychologist that I saw was very sympathetic as compared to the male psychiatrists that looked after my husband--they couldn't care less! They didn't give a damn what I was feeling or what I was going through. They didn't even listen to my end of the story. If you can't sympathize with someone, you can't help them. I can't see how males can understand fully how a female functions.

H: There are so many things that as women we take responsibility for. And I don't necessarily think that we should. If we could find it in ourselves to let some of that go, our depression may not seem so bad. There's too much heaped on women's backs and it's not all theirs. And, it's not fair! You should get angry about it. Throw it back! I mean it's not ours! I think that when women come of age, probably a lot less depressed women will be around.

F: There's a certain reality to "life is shitty" sometimes. It's important to look back through your life for the accumulation of subtle situations and messages that led to the depression, to your not really feeling very good about yourself. Find supportive friends that will be available and stay in touch with them. Let them [depressed women] know they're valuable. You don't have to be happy and feeling good about yourself to be valuable and important. That's okay. It's important to accept the "dark side" of personality. I think it's important to allow people to be depressed. I think it's really okay, you're still valuable. A good support group is important. Women supporting women can be really great, but it is another thing to get women who have been conditioned by society to believe that. I think it's important for women to be with women.

G: I think it's easier for women to get depressed about things, because they're so powerless over things. I honestly couldn't believe that horrible things would go on and nobody would do anything about them. I used to get incredibly depressed about things like that. Women have, maybe, been a little bit protected from those kinds of things. Women become depressed more, because they are more powerless over all those things. I just wish that women had that sort of rapport with other women. Just hug them. I really have a hard time hugging people, too, but just be more open with your emotions. Tell them that we do care about them and it's okay to be depressed. Especially now, when women are becoming more powerful and

are becoming self-supporting and have careers and they're not supposed to show those emotions. I hope they don't go over to men's side and control their emotions more, because they can share so many things that men can't share. I think a lot of women, even today, grow up thinking that they don't have to accept responsibility for themselves. That somebody will take care of them--their husband, their dad, whatever. I think it's really important for women to be responsible for themselves first. Before they find a husband, anything else, they have to be responsible for themselves. Accept your depression. Accept the consequences of that depression. All the time I was depressed, I didn't have to accept responsibility. Maybe that's why women become depressed. Use your own strengths! You just have to accept responsibility.

C: Tell them that it doesn't last forever and it does go away. I think that would be the most important thing I'd want to tell anyone. If she's being very limited in terms of what she can do, because of expectations on women, that may play quite a large role in some of the things that happen to women. Look outside of herself and not be willing to accept all the blame for what has happened. Look at society as society having prescribed a role that's really impossible to fill and still feel good about yourself. Be willing to be flexible and define your own role for yourself!

J: Depression is as normal an event in life as falling down and scraping your knee. You dont' have to be marked because of the fact that you're depressed and thought of as anything less. Depression can be a growing experience. It can be a point of growth for anyone and it's too bad it has to be in the form of depression, but depression isn't totally negative. You will get out of the depression. I strongly believe that women will get out of depression. Utilize the other people that are around you and say, "This is what I need." Don't feel silly if you have to say to a friend or somebody, "I just need you to stay overnight and sleep on my couch for one night, so that

I know if I wake up with a nightmare in the middle of the night, that you're there to come and talk me out of it." Or, "I may be calling you, because I'm in the middle of an anxiety attack. I'm not really going to do anything stupid, I just feel like I'm going to do something stupid, so, please, will you be there to listen at that time?" Utilize people like that. Realize that people owe that much to you and you don't have to repay back a thousand times over afterwards. We owe that to each other as human beings. Writing poetry can be painful for some people, too. Acting, Dancing. Anything where you're going on beyond just your outer self and having to call from within. At the time you're in depression, you're not going to see a way out, but there is a way out. All you're going to feel is the pain. Let yourself feel what it is you're feeling instead of saying, "I know I'm feeling really anxious right now, but maybe if I forget about it and do this and this, it'll go away." Just let it happen--right then and there. Then it can dissipate instead of backing up.

VI. DISCUSSION

The voyage that metaphorically describes this study is coming to an end. The boat has been docked and the sails put away. Now, it is time to reflect on the voyage in total and make the last entries in the log book. This is the captain's time to bring the various aspects of that voyage together and make her final statements about that voyage in its totality. What was it all about and what has she learned? The following discussion answers those question in four sections: A) Balance / Imbalance and Other Dichotomies; B) Meaning; C) Literature Revisited; and D) Implications for Counselling.

A. Balance / Imbalance and Other Dichotomies

Depression has been described in Chapter V in terms of its parts; themes, metaphors, and messages to depressed women. These parts must be put together in some way so that the whole picture of depression, as it emerged in this study, can be seen. Because any whole is greater than the sum of its parts, that difference between the whole and the sum needs to be addressed. In Chapter III, the discussion of Gadamer's hermeneutics addresses this difference as the application of the reader, i.e., as the reader, I belong to what I read and am inextricably a part of the meaning I apprehend as I bring the parts of this study together. Therefore, the following picture of depression bears my imprint. As a composite picture, it resembles parts of each woman's experience, but it also does not resemble any singular experience. It loses something from each experience in the process. Primarily, each woman would probably feel this composite picture was out of balance when compared to her individual experience. Like depression, it may be a meaningful picture, but it is also a picture of imbalance.

> This is a period picture of a woman and her world. The period is called depression. As I focus on the woman, I notice that her eyes are wet from crying, her well of tears always threatening to overflow. She may be aware of her surroundings, but she appears to be focused inward. She seems to be active and inactive at the same time. Her activity inside creates a paralysis or inactivity in her outer world or her busyness in her outside world is her way of avoiding the call to go inside. Regardless, at this moment she is inside herself.

This woman has gone inside in search of her "self." She is struggling with questions of how she is defined, how she is valued, and how she is at fault. She is searching for acceptance--mostly her own--and that search has led her to an inner space known only to her--her inner space of feelings and thoughts. The light in that space is dim, so her feelings and thoughts are dark. She feels uncomfortable in that darkness and her fear escalates. She is afraid of being rejected, afraid of being dependent, afraid of being abnormal or different, afraid to make decisions, afraid of hurting others, afraid of the future, afraid of her fear, and afraid of being overwhelmed by darkness. She has stepped into a space inside herself that was demanding her attention by offering her the illusion of protection and her fear is closing the door.

This woman is feeling her aloneness, her isolation, and has lost her feeling of connection to the outside world and to others. She feels unable to talk about her feelings, thoughts, and inner space. Feeling limited and trapped in that space heightens her awareness of being alone, of her pain in that aloneness, and of her fear that there is no way out. The door to that space closes as she hides behind it, too fatigued to hold it open any longer. If there was ever a comfort in that space, it was replaced by pain when the door closed. She has lost her sense of control, her sense of support and belonging, her spirit, her direction, and her physical contact with the world outside and others in it. At this depth of depression, she appears frozen and helpless. The issues that called her inside remain unresolved and hidden. The acceptance she sought seems out of reach. She is a woman deep inside herself, in darkness, and alone.

As I shift my focus to the setting in which this woman is pictured, I become aware of her outside world--the context in which she is situated. It is sometimes hard to tell if this context was painted in a period before the woman's depression or at the same time. It is a context of change and loss, a context that seems to be controlled by someone else, and a context that has taught this woman to be helpless. Whether she helped to paint this outside world or it was painted by someone else, she doesn't seem to fit that setting and appears painfully uncomfortable in it. I get the sense that she would paint a different setting for

herself if she were able to come outside or maybe she would simply find an eraser and remove herself from the picture.

Stepping back and looking at the total picture, I am drawn to the concept of balance. This is a picture of imbalance that is reflected in the woman's pain and isolation. What would bring this picture into balance--a change in the woman, a change in the setting, or both? I walk away from this picture with a sense that both the woman and the setting need to change in some way in order for the picture to come into a sense of balance for me.

Throughout this study, my attention has been drawn to the concept of balance. Depression emerges for me through descriptive themes and each theme describes imbalance of some kind. For example, the dark side of feeling outweighs the light side of feeling, negative thoughts outweigh positive thoughts, failures outweigh successes, and the sense of rejection outweighs the sense of acceptance. Depression itself seems to outweigh other experiences to the point of exclusion. The total picture is one of imbalance.

The concept of balance as it emerged for me during this study is one that appreciates and accepts both extremes on the balance-board, but equally accepts the subtle shifts in weight that occur between these extremes. Before this study, I would have described balance as a static position created by an equal weight at both ends of the board, at both extremes. Now, I see balance as a dynamic process that describes life and psychological health. Each extreme is defined by the other. Both are necessary, no matter what the length of the board, or balance is a meaningless concept. For me, as a result of this study, life is an exploration of the length of the board, an exploration that can only exist because both ends of the board exist. Similarly, I can only experience balance because I have experienced imbalance, and I can only recognize imbalance because I have experienced balance.

I am reminded of circus or vaudeville acts where the performer must adjust her position on a board in response to the ball that is moving beneath that board. I am reminded of snow skiing where the skier must adjust in response to the changing terrain in order to maintain her balance. I am also reminded that both the performer and skier jeopardize their balance when they fail to attend to that movement or terrain or when

the change beneath them becomes too extreme for their ability to adjust and respond. Both failure to attend and inability to adjust in response to changes result in imbalance for the performer, the skier, and the depressed woman. As a result of this imbalance, all three are threatened by pain and injury, and in some cases, death. For all three, balance is an active, dynamic process. For all three, flexibility is the key to survival and the key to their control.

As a child, I remember playing with a seesaw and learning all the variables that made it possible for me to be a player on that board. One variable was a partner. That partner had to be similar in weight to me in order for us to play with the balance and imbalance of the seesaw. If the partner weighed more or less than I did, some adjustment had to be made in another variable. The lighter child had to sit further toward the extreme end of the board and the heavier child further toward the center of the board on their respective ends. If the discrepancy in weight between the two children was too great, that adjustment wouldn't work and the variable pivot point had to be adjusted. When the pivot point was moved closer to one end of the board, the length of board on each side of that pivot point changed. The lighter child had the longest length of board on her end in order to be a player in this activity. Other variations were adding weight to one end of the board by adding other children or other things that would provide some kind of equality between the two ends of the board. Playing on a seesaw was not without its surprises. There were times when the pivot point was changed or in a different spot than we expected, times when the child on the other end unexpectedly got off, or the child that was adding weight to our end got off. In every instance, balance was lost and in some instances, I hit the ground with a resounding thud!

This seesaw activity and its variations may speak, metaphorically, for my depression experience and the experiences of the eight women in this study. The pivot point represents changes in the outside world that cause the players to adjust to that change. When that change is abrupt, radical, or unexpected, the adjustment is greater and takes more time. When the pivot point is constantly changing, the players have to constantly adjust and eventually may tire of the game and quit. For these players, balance seems impossible to achieve. Differences in the players' weights represent differences in power and control. The heavier player has more power and control over the board.

Only if that player shares his or her power by moving toward the lighter player or if the lighter player moves away from the heavier player can the two participate in the activity. Adjusting the board over the pivot point so that the lighter player has a greater length of board on her end represents the woman's greater distance from the center and her greater amount of vulnerability to depression. For some women, that length of board resulted from accumulated unresolved issues or accumulated inattention to their needs and feelings. For some, it resulted from greater responsibilities, especially in relationships. For others, it resulted from a lack of support. For all, it resulted from being too far away from their center--acceptance of who they are.

Adding weight to the light end of the board represents support. For some women this support was other people, particularly women friends and family. For others, this support was something that gave them weight and identity, such as a job or career. Having those people or that identity allowed them to be active in finding balance. Losing those people or that identity resulted in depression.

Finally, the other player getting off the board represents losses other than support and career. These were most often losses of people. These people were lost through separation of some kind, e.g., divorce and death, and that loss was felt by these women. For some women, their identity was tied to that other person and the loss of that identity was part of her depression. For others, that person gave them a sense of belonging, connectedness, and gave them physical contact, all of which were lost when that person was gone. For a few women, the player on the other end of the board was their spirit or sense of direction in life. When that player was no longer on the other end of the board, these women became depressed.

I can see each of the women in this study, including myself, in one or more of these variations. Each of us described adjusting to shifts in balance, some gradual, others radical in both adjustment and shift. Each of us described some point in our depression as losing the ability to participate in life when we lost the possibility of balance. For each of us, it did not seem as important to achieve and maintain balance as it was to know that balance was possible. All of us were willing to live with some imbalance as long as we could also anticipate balance. Both are a part of life. Both are acceptable, when they are not too extreme or too long in duration. For each of us, the

intensity of her depression was related to the extremity and duration of her experience of imbalance.

Many women spoke of increased activity prior to a period of inactivity as they described their depression experiences. It seems reasonable that this increase in activity was their reaction to a sense of pending imbalance inside or outside or both. Women who spoke of control increased their controlling behavior when they sensed their loss of control. Women who spoke of leading active lives increased their activities when they sensed their loss of activity. Women who spoke of fear increased their protective behavior in response to their increased fear. Eventually, each of these women became inactive when her efforts did not bring the possibility of balance back into her life.

Some women spoke of functioning as an index of their depression. These women equated inability to function in a familiar way with their depression. For these women, being able to function meant they were still in the game, still on the seesaw, and balance was still possible, no matter how far away. Some of these women spoke of anti-depressant medication as a means of maintaining some ability to function in their world. Whether or not they used medication, each of these women described the intensity of their depression in terms of their ability to function. Functioning became their barometer for depression.

Several dichotomies, descriptive of the opposite ends of a seesaw or balance board, emerged from these women's descriptions of depression: inside / outside, independence / dependence, conformity / non-conformity, social / personal, change / stability, loss / gain, alone / together, self / others, and fear / safety. Each represents a partnership of opposites that makes movement of the board possible. When either end is lost, balance does not seem possible. When either end gets too much weight or attention (intensity or duration), balance does not seem possible. In both instances, the board becomes imbalanced and the woman, depressed.

Underlying each dichotomy is the dichotomy of good / bad, right / wrong, acceptance / rejection, white / black, or plus / minus. This is the dichotomy of value. One end of the board is seen as more desirable than the other. Each woman in this study valued one end more than the other. Consequently, she became depressed when she found herself too far away from the things she valued. Whether or not a woman

recognized a theme as an important factor in her depression was contingent on her sense of that distance. For the women who felt a loss in their life was balanced by a concomitant gain, loss wasn't an important factor. For the women who felt change in their life was balanced by a concomitant stability, change was not an important factor. For each woman, recognition of a theme as important to her experience of depression was contingent on her sense of imbalance between some dichotomy which placed her exclusively on the undesirable end of that dichotomy.

During this study, the key to understanding depression that emerged for me was the dichotomy of balance/imbalance. Both are necessary and acceptable parts of life, but they need each other for life to be a dynamic, growing process. Either extreme is static if that movement and activity are absent. In these women's descriptions, depression is the extreme of imbalance. In many descriptions, balance in their lives is lost, out of sight, or out of reach. This was described as "no way out." These women could not see the possibility of balance when they were depressed. These women wanted to be active participants in life. Being stranded on one end of the board took away their ability to participate. Today, these women are participating in their lives in varying degrees. Each spoke of being alert to indications that tell them when they are getting too far toward one end and of being able to take action to keep from becoming depressed again. Today, these women do not consider themselves depressed and they know how to take steps to keep their particular dichotomies in balance.

B. Meaning

Each woman in this study wanted her depression experience to have meaning for others as well as for herself. That is why she volunteered to participate in this study. I can only hope that the reader will find meaning for herself. I know that I have found it. As a result of this study, I believe depression is a meaningful experience for women, even when that meaning does not emerge until the experience is over. For each of these women, the meaning her experience holds for herself is most evident in her message to depressed women. Therefore, the following is a composite message to depressed women about the meaning of that experience:

Depression is just one of life's experiences. Like all experiences, it has a beginning and an end. It is not a lifelong illness, but an experience that will end. Sometimes life isn't very pleasant, it is dark and painful. Accept depression as an understandable reaction to life's unpleasantness. The only way we know we are not in pain is because we have experienced pain. The only way we know we are not depressed is because we have experienced depression. It's okay to be depressed sometimes. We are valuable, even when we are depressed!

Don't rush through depression. It is our way of buying time for ourselves--time to attend to ourselves, our feelings, our thoughts, our needs, and our wants. It is our time to respond to ourselves, rather than others. It is our time to do our inner work. That work is coming to terms with our "self," integrating or reintegrating, defining or redefining ourselves and our needs. Learn to accept emotions, not control them. Feel what you are feeling. Don't push those feelings away. Look at your responsibilities. Give back the ones that belong to someone else and accept your own. Recognize your strengths, resources, and flexibility. Use them in your own behalf as well as for others. Assert yourself as someone of value, someone with rights, and someone with needs. Get angry when those around you don't recognize that value, those rights, and those needs. You have a right to your anger and it is an acceptable response when these things are not recognized.

Be with women who are supportive and represent a safe place to talk about your internal work. Talk! Sometimes verbalizing what is going on inside can help you figure it out and come to some resolution and direction. Your inner self is as important as your outer self and depression is one way of attending to that inner self and recognizing its value and importance. Finally, look at both your inner self and your outer self, your inner world and your outer world. Your outer world may be what society has taught you to be, but not necessarily who you want to be. Be yourself and define that for yourself. Your depression pain may be a growing pain. Take your time and grow through this experience.

Perhaps, as women, we attend to others at the expense of attending to ourselves, and depression, in some way, legitimizes attending to ourselves. Most of the

women in this study seem to believe that they were socialized to attend to others before themselves. For many of these women, being depressed or attending to themselves was socially unacceptable and they withdrew or isolated themselves. Every woman spoke of thinking there was something wrong with her when she was depressed. At that time, she did not seem to be able to see that something was wrong outside of herself, as well. In retrospect, most of these women recognized problems outside of themselves that contributed to or caused their depression. Perhaps, depression means it is important to attend to ourselves and attend to those things outside of us that prohibit us from doing that.

For me, depression means that I am important, that I deserve attending to, and that something is wrong with any environment that prohibits me from believing that. That is not to say that others are not important and equally deserving of attention. Both are important and must be integrated within a framework of equality for a woman to know who she is and to know that she is of value because of who she is.

C. Literature Revisited

Chapter II presented my view of the literature on depression as I began this study. It represents some of the preconceptions that I took to the hermeneutic encounter described in this study. However, it has been noted in Chapter III that these preconceptions were put at risk, opened to change and reconceptualization, during this encounter. This section revisits the literature on depression and presents my view of the literature from the other side of this encounter.

It has been noted that depression creates a definitional dilemma. Attempts to define depression have been confounded by its use to describe a mood, a symptom, and a syndrome, its varied and often ambiguous symptomotology, and its wide range of duration and severity. Depression appears to be refractory to definition. This study helped me to understand why. Depression is an experience and, like other experiences in life, it can be described, but not defined.

Describing depression is not without its dilemma as well. During this study, I have struggled with the dilemma of recognizing the uniqueness of each woman's experience, while simultaneously recognizing the experience as the common element that brought us

together. It was a struggle with sameness and difference that was reminiscent of a common issue in many of our experiences of depression. Perhaps, in trying to provide a universal or definitive description of depression, we always objectify that experience, i.e., we remove it from the individual who is experiencing depression. Every description will have its exceptions. Depression is an individual experience and, as such, will always be inextricably tied to that one life that is experiencing it.

After meeting the women in this study, I find myself regarding biological theories of depression with greater caution than I did prior to this study. For some reason, these theories seem to have created more problems for these women than they solved. It is difficult to know whether these problems were related to the content of the theories, the way the theories were presented to these women, or the way the theories were interpreted and understood by these women. Regardless, it is important to remember that these are women who fear depression and blame themselves for having been depressed.

Genetic theories address a genetically-linked predisposition or inherent vulnerability to depression; yet, not one woman in this study attributed her depression to a genetic predisposition. However, two women in this study spoke of their current concern that their children might be genetically predisposed to depression and of their guilt in this regard. It is interesting that both of these women had extensive exposure to the medical model of depression. Perhaps, a woman who blames herself for being depressed is vulnerable to blaming herself for passing it on genetically, but finds little or no solace in considering others in what she perceives as her own weakness.

Neurochemical theories have been criticized for presenting a limited focus of symptoms, encouraging dependency and a fatalistic view of remission, and putting women at risk of being subjected to drug treatment without appropriate consideration of life-events and other contributing factors. During the process of this study, the validity of those criticisms seemed to be confirmed by the experiences of the women in this study. Several women spoke of refusing drug treatment, because they did not want to become drug-dependent. They did not want their symptoms removed until they understood what they meant and why they were there. Two women who had taken anti-depressant medication for an extensive period spoke of their concern about living

without medication. One woman is still on mild doses and the other had just come off her drug-treatment. Both women indicated they would use drug treatment again if they sensed depression returning. Both spoke of depression as an illness and expressed their concern that they may always be vulnerable to depression. Another woman who took anti-depressants for a few months during her depression attributes a permanent change in her sleep patterns to that medication. Most of the women spoke of medication as a temporary solution to extreme symptoms of depression, especially when they were in a situation that demanded their continuing to be able to function, but many of these same women did not take medication when they were depressed and would not in the future, if depression returned.

Endocrinology theories did not seem relevant to these women's experiences of depression. None of these women described their depression in terms of their biological life-cycles and there was no indication in their descriptions that hormonal changes contributed to their depression experiences.

As a result of this study, I have more concern about the medical model of depression presented in biological theories than I did before. The women in this study who encountered that model and were treated by it carry more residual fear and a more fatalistic view of depression than those women who did not encounter that model. If we look at the symptoms described in every woman's experience, every woman in this study would have been diagnosed by that model as depressed; yet, not all of the women view depression as an illness, have concerns about their children inheriting a predisposition to depression, or would take medication for depression. My concern is that biological theories, the medical model of depression, and the ways in which they are interpreted by depressed women can emphasize a weakness in the individual that cannot be changed, only controlled, and puts that control in the hands of the medical community. Its limited focus can ignore life-events and circumstances around the individual and ignore her personal resources for change. Moreover, it can perpetuate fear, self-blame, and dependency--all of which are painfully reminiscent of the depression experience.

In revisiting psychoanalytic theories of depression, I am reminded of the double-bind they present for women. They locate causal factors in depression in early

childhood experiences--experiences that were out of the control of that child and that cannot be changed, then criticize the grown-up for being self-indulgent, masochistic, and depressed. Narcissism and oral dependency are negative terms applied to the human need for love and affection. During the depression experience, the women in this study may have had an extreme need for love and affection, because they were deprived of these qualities in their lives in some way. It seems psychoanalytic theory would blame these women for their extreme need, instead of blaming the environment for their deprivation. Low self-esteem as a result of emotional loss had its base in reality for the women in this study. Emotionally valued objects were lost and these women reacted to their sense of loss. Validating and accepting the reality of that loss may have encouraged the recovery of these women, while viewing it as a weakness may have contributed to their low self-esteem. Moreover, it seems that psychoanalytic theory reinforces society's censure on women's expression of anger which encourages them to turn that anger inward, then labels these women negatively as masochistic and depressed. Moreover, psychoanalytic theory describes women in this society, but blames them for that position and describes women's reaction to that position in society, but diagnoses them weak and depressed. The double-bind for women in psychoanalytic theory is that they cannot exhibit the qualities of femininity prescribed by this theory without also being diagnosed sick by that theory.

Returning to behavioral theories of depression after this study, I find myself concerned that the lack of positive reinforcement for women goes farther than these theories indicate. Not only are women encouraged by sex-role stereotyping to develop behaviors that are generally not valued and, therefore, not positively reinforced, they are also caught in another double-bind that seems to make positive reinforcement impossible no matter what behavior they exhibit. If they successfully develop behaviors prescribed by the female sex-role stereotype, their behaviors are not valued by society and not positively reinforced. If they exhibit behaviors outside of that stereotype, they are destined to negative reinforcement or punishment. Furthermore, many of these women became depressed when they feared that who they were was not what society wanted them to be. Even when they had learned to successfully exhibit the behaviors prescribed by their sex-role stereotype, they felt like frauds and couldn't accept any positive

reinforcement that that behavior elicited. As a result of this study, I am inclined to view behavioral theories as some of the best evidence that society is depressing for women. Society holds the power of reinforcement for these women, but few of these women felt positive recognition for their being-in-the-world was possible.

Cognitive theories of depression seem to imply that there is something wrong with a depressed woman's perception and thinking. They suggest that depressed women hold stable, long-standing pejorative views of themselves independent of what actually occurs in their environment. For me, this study challenges cognitive theory. I did not find these women's cognitions distortions of events and circumstances in their environment. I could not challenge the reality these women found in their experiences; therefore, I could not challenge their cognitions. On the contrary, I found the life-events and circumstances described by these women to be understandably depressing for anyone and their depression to be a reaction to their experiences and environment. I would be hard pressed to convince these women that their cognitions were in error. Moreover, I would not be inclined to do so.

For some time, I have struggled with a sense that self-in-relation theory is not a theory of the healthy personality. After this study, I begin to understand why. It, like theories that stress autonomy, is without balance. Considering the experiences of the women in this study, it would seem that some balance between autonomy and self-in-relation would predict less experience of depression by valuing both independence and dependence. J in this study is one such example. Part of her depression experience was related to her struggle to find one without the loss of the other. In more subtle ways, this same struggle appeared in the other women's experiences as well. Like behavioral and cognitive theories, self-in-relation theory tends to shift my focus to the problem of societal values rather than women's values. Based on the experiences of the women in this study, we must find a way to value women, such that they can also value themselves.

Existential theory of depression seems to be borne out in the descriptions of that experience presented by the women in this study. Many of these women spoke of being alienated from their authentic selves. Many of these women suppressed knowing and accepting themselves in some way as they pursued the recognition and acceptance

of others. Many of them spoke of anxiety preceding depression. Most spoke of low self-esteem. In many ways, existential theory and my concept of balance / imbalance seem to be in accord. However, there is one notable difference-- existential theory puts the onus of balance on the individual and my concept of balance / imbalance recognizes the responsibility of both the individual and her outside environment in achieving balance. In fact, I am inclined to believe that society must accept the majority of responsibility for depression in women.

Sociological theories of depression have addressed stress and gender-related factors that have become associated with depression in women. In this study, there seemed to be no stress associated with socioeconomics cited in any of these women's experience of depression. There was one woman who indicated that marriage and children in the home were stress factors in her depression. Several women indicated that work-related stress or the stress of losing their work-definition were factors in their depression. In addition, most women described their loss of self-esteem support or loss of a relationship as stressful and related to their experience of depression. Overall, the experiences described by the women in this study seem to confirm that stress (particularly stress related to work, relationships, and loss of support) is a factor in women's experience of depression.

Most of the women in this study indicated that they wanted to deal with their depression by themselves. There was no indication that help-seeking was their preferred behavior. On the contrary, several women avoided seeking help, while some others sought help only when their depression threatened to overwhelm them. For many of these women, help-seeking behavior only occurred after they had tried everything within their power in this society to overcome their depression by themselves.

In this study, both women who restricted themselves to the constraints of the female sex-role stereotype and those who rebelled against it were aware of the values implied and denied by that stereotype. These women were looking for a way to value themselves and be valued by others. The female stereotype did not offer them a way to make this possible. For some women, this was more of a problem than it was for others. While it only contributed to the depression of some of these women, the female stereotype did not offer any of them a way of knowing, accepting, and valuing their

authentic selves.

In many ways, sociological theories of depression balance psychological theories by emphasizing the outside world of women. None of the theories seems totally accurate in describing the experiences of the women in this study. Indeed, some seem quite inaccurate. It has been noted that some aspects of these various theories of depression were confirmed in the experiences of the women in this study, while other aspects seemed to be irrrelevant or non-confirmed. Perhaps, no one theory will ever explain or describe depression in such a way that it fits the experiences of all the individuals who have that experience. Perhaps, in recognizing and accepting its uniqueness for the individual and in recognizing and accepting both inside and outside factors that contribute to that experience, we will begin to lessen the damage that experience does to the individual experiencing depression.

D. Implications for Counselling

This study has several implications for counselling depressed women. These implications are found in its methodology of hermeneutics, in its impact on the women who participated, and in its descriptive themes which emerged from the experiences of the women who participated. The discussion of each of these implications necessarily bears the imprints of my being-in-the-world, my being-in-the-study, and my being-the-interpreter. It also represents the way I view counselling depressed women as a result of this study.

Gadamer's hermeneutics has two implications for counselling depressed women: 1) view the experience in the context of the unique life of each woman, and, 2) question our preconceptions of depression to determine where and when they help us to understand the individual experience of depression. It is important that the depression experience has meaning for the woman. A meaningful experience is more acceptable than a meaningless experience and most often she will present herself and her experience as meaningless or pointless. Gadamer suggests that any experience's meaning belongs to the unity of the self that is having that experience, so it seems important that the counsellor remain open and sensitive to that one life that is having the experience of depression. By becoming aware of and sensitive to the unity of the

woman's life, a counsellor may be able to reframe her depression experience in such a way that her depression becomes meaningful and acceptable. It is important to remember that most women present themselves and their depression as unacceptable and unworthwhile. A counsellor who can shift the perspective of depression to acceptance and value can open the door for the depressed woman to accept and value herself.

Further, Gadamer calls us to question our preconceptions of depression to determine "the true prejudices, by which we understand, from the false ones by which we misunderstand" (1986, p. 266). As counsellors, we are all vulnerable to our preconceptions of depression. When we assume these preconceptions are tantamount to understanding, we open ourselves to misunderstanding the woman's experience of depression. It seems that Gadamer implies that our preconceptions of depression should be held open to acceptance or rejection in light of the depressed woman's description of her experience. It is an individual experience that is brought to counselling, not a textbook case or general experience. It is the individual experience described by the depressed woman that is the issue of counselling and it is that experience that may reject our preconceptions.

The responses of the women to the research process employed in this study have implications for counselling. First, they expressed appreciation for being considered the experts of their experiences. As counsellors, we sometimes think a client expects us to be the expert and we fall into the trap of trying to live up to that expectation. Here, the women in this study imply that the depressed woman would gain some recognition, value, and acceptance by being regarded as the best source of information about her experience. Respecting her knowledge of her depression can contribute to her sense of self-respect and power and, possibly, facilitate her understanding toward overcoming her depression. Second, each woman in this study expressed some benefit from reading and interpreting her own experience in its typed transcript form. While audio-taping and transcribing interviews with depressed women would be time consuming and costly, there is some implication for counselling. As counsellors, we can describe her experience back to her and invite her to join us in interpreting that experience. Not only does this process respect her and what she

offers in interpreting skills, but it allows the depressed woman to step outside of her experience, no matter how briefly, to see it from another perspective. During the research process, several women spoke of apprehending meaning in their depression experience that they had not apprehended before. This seems to imply that the process of describing, redescribing, and collaborating on interpretation may enhance the possibility of finding meaning in that experience--not meaning forced on the experience by the counsellor, but meaning that emerges for both the depressed woman and the counsellor. Both have something to contribute to the other, and both have something to learn from the other. The power differential in counselling becomes more equal and the depressed woman may experience respect and value even in her depression.

Finally, the descriptive themes in this study may provide guidelines for counselling depressed women. Each theme represents an area of exploration that may be pursued in counselling. Some women may find more importance in some themes than in others, while some may find some themes irrelevant to their experience. My experience in counselling depressed women has indicated that some combination of these themes is present in some variation in each experience. However, the exploration of these themes should remain sensitive to the subtle nuances and variations that tell us these themes are being presented in a new and unique voice. Above all, each voice must be heard--by us as well as by the individual.

VII. EPILOGUE

Like a post script in a letter, this chapter includes material that emerged after the writing of this dissertation; yet, it is material that must be included in order for me to have a sense of its completion. In addition, like a post script, this material will be brief.

Phase IV of the research procedure described in Chapter IV began during the last week of July, 1987. Seven of the women who participated in this study were contacted by telephone and a time and place for the hand-delivery of a copy of this dissertation was arranged. Four women elected to receive a copy at a work setting, two, at home, and one, at a restaurant. During these meetings, fifteen to forty-five minutes was spent chatting and re-establishing our connection. In addition, each woman was asked to read her copy and be prepared to give me her response and feedback in regard to this dissertation during the third week of August, 1987. All of these women were able to give me their feedback through telephone conversations during that week.

None of these women expressed any concern that their anonymity had been compromised or that they or their experiences had been inaccurately represented. None expressed a desire to make editing changes in the manuscript, but three women made observations that are appropriately included in this chapter. E expressed her wish that more emphasis could be given to the spiritual, magical, or synchronicity aspect of the experience of depression. G observed that the medical model of depression had been "dismissed too abruptly" for her, because recent information about and medication for pre-menstrual tension had helped her to avoid some of her mood swings. D commented on a few points in her experience to make certain we understood each other on those points. Each woman's observation was consistent with my experience of that woman, i.e., I could agree with her observation in light of her experience of depression. However, in light of our aggregate experience of depression, neither she nor I required a change in this manuscript.

All of these women responded enthusiastically to the dissertation and to their participation in this study. Each woman was quite generous with positive reactions to the dissertation and study as a whole:

D: wonderful piece of work

E: moving; engrossed

F: joyous

G: exciting; really pleased

H: fantastic

J: Quite interesting; eye-opener

K: Wonderful; fantastic; moving; terrific

Feelings generated by reading this dissertation were described as hopeful, validated, joyful, and having-a-voice. One woman said it made her sad to think there may be so many women "out there" who are or have been depressed. Another woman stated that she must be avoiding something, because reading her copy "brought up old feelings." However, this discovery was presented as more helpful than distressful for her.

Several women expressed a desire for this material to be published in a book or pamphlet format so that it could be more widely disseminated and more women could read it. Several had loaned a copy to a friend to read. For these seven women the study had been a validating, positive experience and they wanted to share it with others. Through their feedback, they were validating me and this work which had been a positive experience in my life.

For various reasons, the eighth woman who participated in this study did not receive a copy of this dissertation until the last week of Septemer, 1987, and was not able to give her feedback at this writing. However, during our meeting, we explored how the delay had occurred and speculated on why the delay may have been necessary.

There were concrete reasons and events that could account for my delay in delivering a copy to this woman, but none of these touch upon what seems to me to be the most significant reason: I didn't want this experience to end! Perhaps that is a danger in any type of research that requires the researcher to immerse herself in the work, in the experiences of the participants, and in her own experience. For me, this has been a special, rich experience and I find myself reluctant to bring it to a close. I have spent one year with these women, their experiences, and this work as my intimate daily companions. I have grown with them through our dialogues--both in our actual conversations and in my journal entries. For me, bringing this work to a close has become a metaphor for losing my companions. Therefore, it seems reasonable that I would resist this growth-point and delay in the final steps that signify the closing of this

document and the closing of this volume of my personal journal.

Through this study, I am impressed by the value of reflecting on our experiences. It is through this reflection that we determine which parts of the experience to take with us and which parts to leave behind. In addition, reflection allows us to understand that we can return to our experiences for further examination and reflection. Through our experiences we understand, but that understanding is always open to growth and change.

By returning to Gadamer (1986), I am finally able to bring this experience to an end--not The End, but an end, nonetheless:

> Everything that is experienced is experienced by oneself, and it is part of its meaning that it belongs to the unity of this self and thus contains an inalienable and irreplaceable relation to the whole of this one life. Thus its being is not exhausted in what can be said of it and what can be grasped as its meaning. The autobiographical or biographical reflection, in which its meaning is determined, remains fused with the whole movement of life and constantly, accompanies it. It is practically the mode of being of experience to be so determinative that one is never finished with it. [p. 60]

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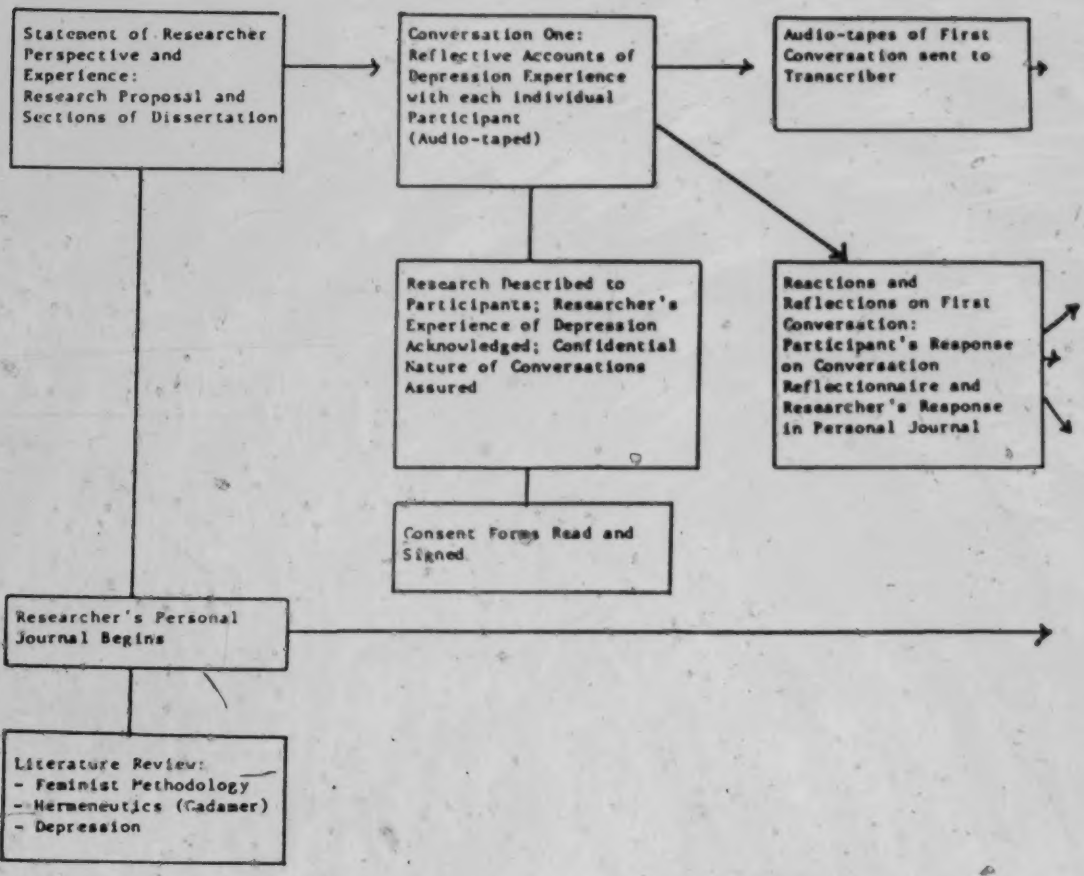
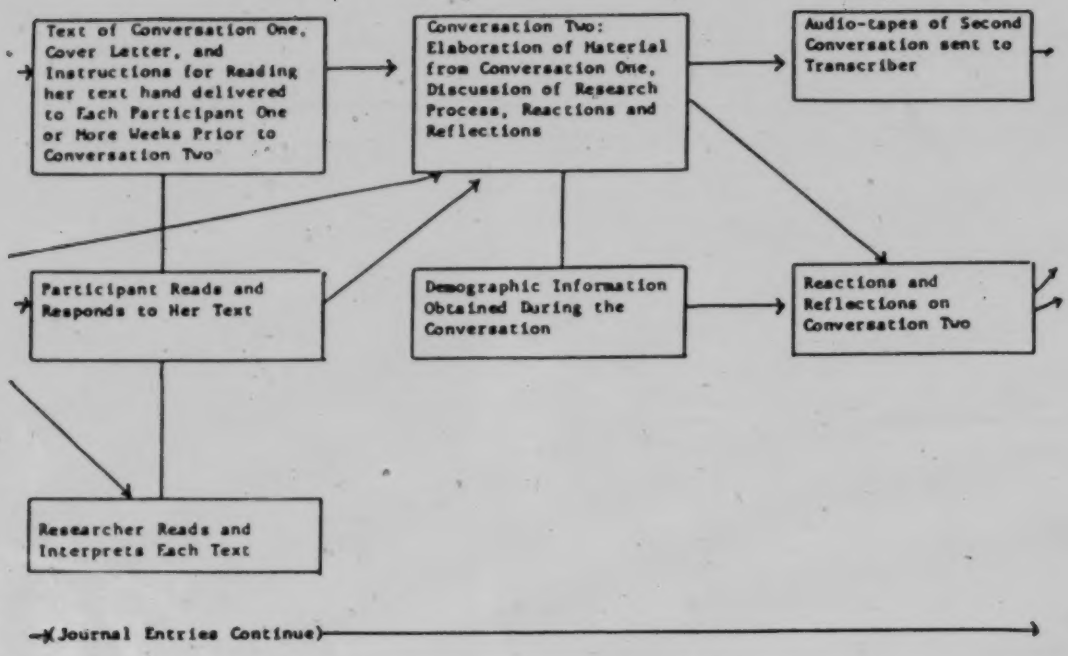
APPENDIX A

RESEARCH PARADIGM PRESENTED IN FOUR PHASES

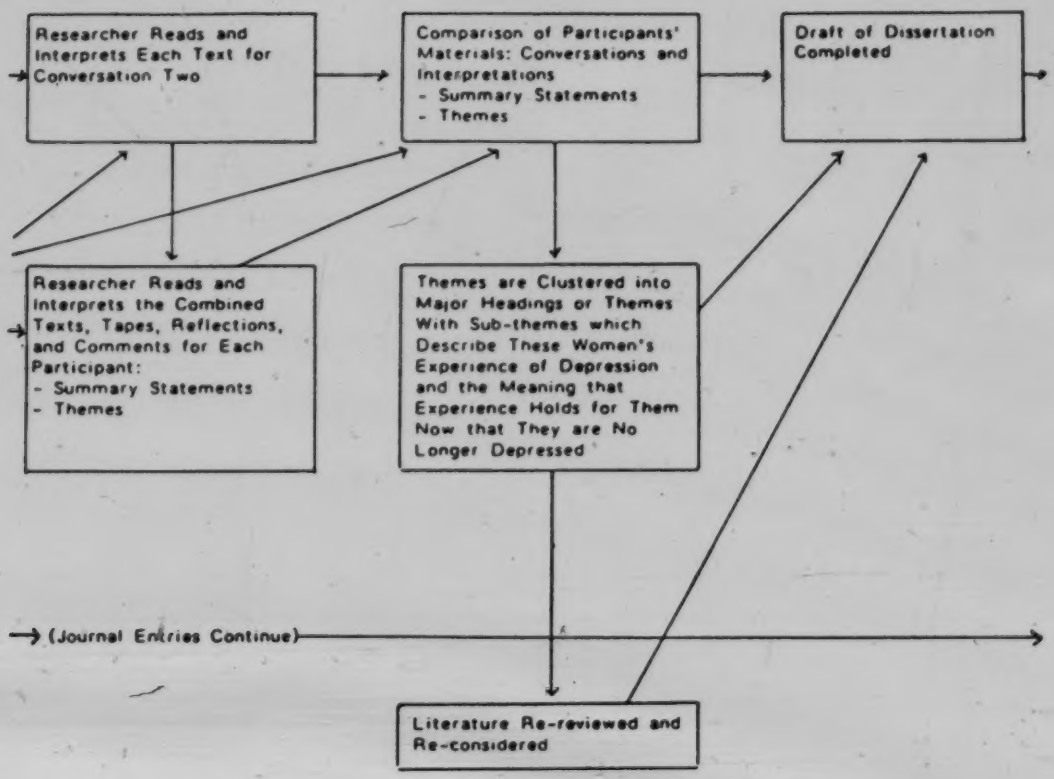
RESEARCH PARADIGM: PHASE I


Statement of Researcher Perspective and Experience: Research Proposal and Sections of Dissertation
Conversation One: Reflective Accounts of Depression Experience with each individual Participant (Audio-taped)
Audio-tapes of First Conversation sent to Transcriber
Research Described to Participants; Researcher's Experience of Depression Acknowledged; Confidential Nature of Conversations Assured
Reactions and Reflections on First Conversation: Participant's Response on Conversation Reflectionnaire and Researcher's Response in Personal Journal
Consent Forms Read and Signed
Researcher's Personal Journal Begins
Literature Review:
- Feminist Methodology
- Hermeneutics (Gadamer)
- Depression

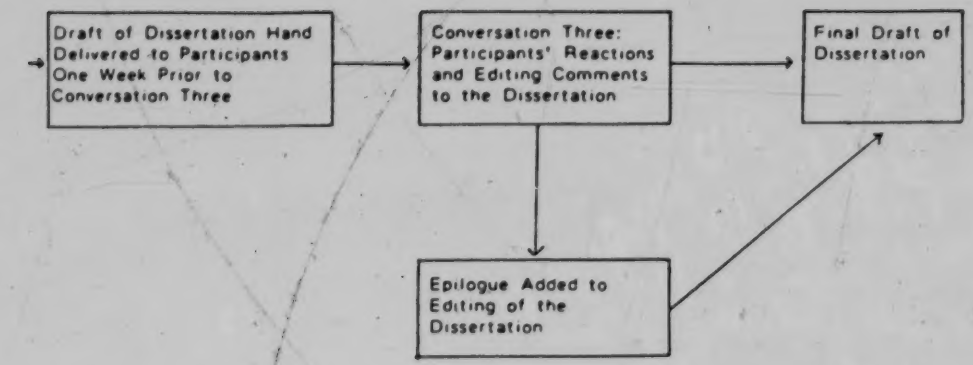
RESEARCH PARADIGM: PHASE II


Text of Conversation One, Cover Letter, and Instructions for Reading her text hand delivered to Each Participant One or More Weeks Prior to Conversation Two
Conversation Two: Elaboration of Material from Conversation One, Discussion of Research Process, Reactions and Reflections
Audio-tapes of Second Conversation sent to Transcriber
Participant Reads and Responds to Her Text
Demographic Information Obtained During the Conversation
Reactions and Reflections on Conversation Two
Researcher Reads and Interprets Each Text
(Journal Entries Continue)

RESEARCH PARADIGM: PHASE III


Researcher Reads and Interprets Each Text for Conversation Two
Comparison of Participants' Materials: Conversations and Interpretations
- Summary Statements
- Themes
Draft of Dissertation Completed
Researcher Reads and Interprets the Combined Texts, Tapes, Reflections, and Comments for Each Participant:
- Summary Statements
- Themes
Themes are Clustered into Major Headings or Themes With Sub-themes which Describe These Women's Experience of Depression and the Meaning that Experience Holds for Them Now that They are No Longer Depressed
(Journal Entries Continue)
Literature Re-reviewed and Re-considered

RESEARCH PARADIGM: PHASE IV


Draft of Dissertation Hand Delivered to Participants One Week Prior to Conversation Three
Conversation Three: Participants' Reactions and Editing Comments to the Dissertation
Final Draft of Dissertation
Epilogue Added to Editing of the Dissertation

APPENDIX B

CONSENT TO PARTICIPATE FORM

CONSENT TO PARTICIPATE

I, _____, voluntarily consent to participate in an interview with Marj Holmgren, a graduate student in the Department of Educational Psychology at the University of Alberta. The purpose of the study has been explained to me and I understand that the information given by me will be used solely for research purposes and published in the form of a thesis or otherwise. I further understand that every effort will be made to remove all identifying information. I agree to allow the interview to be tape recorded with the understanding that the tapes will be erased when the research project is complete.

Date _____ Signed _____

Witness _____

APPENDIX C

CONVERSATIONAL REFLECTIONNAIRE

CONVERSATIONAL REFLECTIONNAIRE

During the interim between our conversations, I would appreciate your reflecting on the experience of those conversations and sharing those reflections during our next meeting. I will do the same. Some of the questions we may want to respond to are indicated below. However, we do not have to be restricted to these questions alone. We may want to add others or find some of those questions listed irrelevant.

1. What was it like for you to speak with me about your experiences?
2. What impact, if any, did the conversation have on you" (e.g., on your thoughts, feelings, ways of looking at things, attitudes, new realizations, behavior, etc.). Please be speeific.
3. Do you think you've felt, said, or done anything differently as a result of our conversation? Please explain.
4. If you were telling a friend about our conversation, would you recommend that she participate? Why or why not?
5. What did the conversation mean to you? Please elaborate.
6. Have you any other comments or suggestions regarding the conversation in light of your experience? (Things that are important to you or you think might be helpful to me?)

APPENDIX D

COVER LETTER AND INSTRUCTIONS TO PARTICIPANTS FOR READING TEXT OF FIRST CONVERSATION

The purpose of this study is "to promote our understanding of depression in terms of meaning and experience rather than in terms of illness" (Rowe, 1978). To this end, our first interview / conversation focused on your experience of depression and a transcript of that dialogue is attached.

Part of the preparation for our second meeting involves your reading this transcript for understanding, meaning, and further experience. This can be done in any way that feels comfortable for you; however, the approach I use in reading these transcripts is presented below and you may wish to adapt this approach to your own reading:

1. Read through the entire transcript non-stop to get an overview of the conversation. Have a pencil in hand during the reading so you can quickly mark any words, phrases, or sections that catch your attention. Feel free to mark the text in any way that has meaning for you without interrupting the flow of your reading, e.g., underlining, check marks, question marks, exclamation points, brackets, circles, etc. These are best done in the text or along the right hand margin.
2. Immediately after reading the text, write your feelings, reactions, reflections, and questions about reading the transcript for the first time on the sheet with the heading "First Reading Comments."
3. Whenever it is convenient, read the transcript a second time. This time the reading is more leisurely. Take time to write comments in the left hand margin whenever you feel like it, e.g., clarification, questions, additions, etc. Pause and reflect as you read whenever it feels right for you to do so. Please indicate in the text where you paused in the reading. Mark the text further whenever and wherever you wish or feel it would be helpful to understanding the text.
4. After reading the text, write your feelings, reactions, reflections, and questions about reading the transcript for the second time on the sheet with the heading "Second Reading Comments."
5. Read the transcript text and written comments as many times as you like, whenever you like. Feel free to mark the text as much as you like or feel will help you or me gain further understanding of your experience and its meaning. After each reading, whether you read all of the transcript or only sections, record your

feelings, reactions, reflections, and questions on a sheet marked "Further Reading Comments."

Bring your copy of the transcript, the comment sheets, the reflectionnaire, and any written reflections you have made regarding this experience since our first meeting to the second interview. This is important to the structure of our second conversation and important to our gaining further understanding of the meaning of the experience of depression for women.

Thank you.

First Reading Comments

Date:

Time:

Place:

Second Reading Comments

Date:

Time:

Place:

Further Reading Comments

Date:

Time:

Place:

APPENDIX E

EXAMPLE OF SUMMARY STATEMENTS AND THEMES FROM ONE PARTICIPANT'S TRANSCRIBED CONVERSATION

EXAMPLE OF SUMMARY STATEMENTS AND THEMES FROM ONE PARTICIPANT'S TRANSCRIBED CONVERSATION

Conversation	Summary Statements
M. Okay. Now, here again, I'm going to take a position that I'm from a place that has no idea what that word depression means. Um. So the only way I'm going to know anything about this thing called depression is by how you explain it to me.	
D. [breath]	
M. I really don't want you to tell me what you've read, but I do want you to tell me from your own experience.	
D. What I read, I wouldn't remember anyway, so I can't.	
M. [laugh]	
D. My memory is not very good anymore.	
M. Mmm.	
D. What it felt like? [pause] I didn't want to go out and I didn't' want people to see me in that state, because I thought it was depressing to them to look at anyone--all my thoughts were so negative. So I stayed away from my son quite a bit, because he made a remark about how	D. indicates unacceptability of depression [her own or society's?] Negative thoughts D. withdraws from son and criticism as well as social interaction.

negative I was over the winter. And that annoyed me, so I tried not to see him. I didn't quarrel with him, but I tried not to see him any more than I had to. And I think I felt very lonely, too, because I	D. is lonely.
isolated myself from the rest of the	D. isolated herrself.
world. And even when I did go out, I didn't feel at ease, because I had this notion that people were just looking at	D. feels odd and ill-at-ease in social
me as an odd screwball. [pause] So that was a bit difficult. [pause] I think I found it	situations.
hard to talk to people, too, without letting	D. finds it hard to talk to anyone.
on that I was depressed. But I had two	D. feels a need to cover-up her
neighbors that were very good and used to take me out once in a while. I think I	depression to be socially acceptable. Friends and neighbors important.
can appreciate the fact that my friends were very helpful at that time. [long pause] So, I think I cried a lot, too. [laugh]	D's laugh indicates some embarrassment about crying.
And there was work to do, but I didn't	D has lack of interest in work.
feel like doing it, so the work around the house just stayed there. [pause] So, for a period of about six months or so, I hardly	
did anything, neither inside nor outside. I	D is inactive.
had a job. I was babysitting when that happened and I told the lady that I'd sooner quit, because I didn't think I had	D indicates impatience in situations that
the patience to carry on and do the right thing for the two little kids that were	require response. D's concern that she is incapable, couldn't
there. So she said there was no problem.	do it right.

[Cough] Excuse me. What else can I tell you? [long pause] I think it's bothered me enough, a lot more than I am willing to admit. I thought that depression was for other people, but not for me. Just one of those things that couldn't happen to me, [pause] but it did. I think, too, one of the things that I felt is that I was looked upon as a third-class citizen, because of the depression.

D finds depression unacceptable in herself, uncharacteristic.

D's concern she was viewed by others as less worthwhile than non-depressed citizens.

M. Hmm.

D. And I think that bothered me a heck of a lot.

D bothered by depression as unacceptable in herself

D's Marginal Comments in her Text	Summary Statements
Despair: Utter despair: At one point during the depression I was prescribed ludomil and had an adverse reaction to it. I cried all the time, was ready to climb walls, and felt very helpless. The doctor wanted to refer me to a psychiatrist, but I did not want to go. The thought of dealing with a male psychiatrist was appalling. The saddest thing during this period was that if I was referred to a psy . . . I was not in control of my own life. I got down on my knees and prayed like I had never prayed before. Things eased off as soon as I was taken off the ludomil.	Helplessness and crying attributed to medication (unacceptable in herself). D. fears loss of control over her life. D's despair--plea for help
I had not realized how much the fact that I had been depressed had bothered me until I got back home and started thinking about the interview. It brought back to mind some of the foolish things that happened when I was depressed. I also remember that there was almost a total loss of self esteem during the depression. At times I felt like a child who is still dependent on his mother to look after him, protect him, love him and look after him physically, except that I was an adult and as an adult, I should be able to look after myself.	Depression still unacceptable, things that happened during that time are viewed as "foolish." Loss of self esteem D feels dependent--needs protection and love, but can't accept that neediness as an adult.

Summary Statements	Themes
D. indicates unacceptability of depression [her own or society's?]	I. Unacceptable State
D. feels a need to cover-up her depression to be socially acceptable.	
D's laugh indicates some embarrassment about crying.	
D. finds depression unacceptable in herself, uncharacteristic.	
D's concern she was viewed by others as less worthwhile than non-depressed citizens.	
Depression still unacceptable, things that happened during that time are viewed as "foolish."	
Negative thoughts.	II. Negativity
D's concern that she is incapable, couldn't do it right.	
D. withdraws from son and criticism as well as social interaction.	III. Isolation
Feels odd and ill-at-ease in social situations.	
D. is lonely.	
D. isolated herself.	
D. finds it hard to talk to anyone.	
Friends and neighbors important	IV. Support
D. bothered by depression as unacceptable in herself.	V. Self Definition and Value

Helplessness and crying attributed to medication (unacceptable in herself).
Loss of self esteem.

D. feels dependent--needs protection and love, but can't accept that neediness as an adult.

D. has lack of interest in work. — VI. Action/Inaction

D. is inactive.

D. indicates impatience in situations that require response. — VII. Coping

D. fears loss of control over her life. — VIII. Control

D's despair--plea for help.